

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>DONALD J. RAMSEY</b>			2a. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>1020 PM</b>								
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>JANUARY 10 1903</b>		6. AGE (In years last birthday) <b>65 YRS.</b>		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>15</b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>				
7a. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>			Md.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ADM USN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>POTOMAC</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>11709 ADMIRALS WAY</b>		
14. FATHER'S NAME First Middle Last <b>JAMES RAMSEY</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>GRACE RAYMOND</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>1924-1947 578-40-7490</b>			17. INFORMANT <b>PAMELA C. RAMSEY</b>			Address <b>POTOMAC, MD.</b>			11709 ADMIRALS WAY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE CORONARY ATHEROSCLEROSIS</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>4201</b>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (A) (this hospital) attended the deceased from <b>FEBRUARY 12, 1968</b> , to <b>FEBRUARY 25, 1968</b> , that (A) (we) last saw the deceased alive on <b>FEBRUARY 25, 1968</b> , and that in (My) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Peter T. Kirchner</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>27 FEB 1968</b>						
22d. PHYSICIAN'S NAME (Type) <b>PETER T. KIRCHNER STAFF MD</b>								22e. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>						
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b> <b>7557 Wisconsin Ave., Bethesda, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>						

TO THE SECRETARY OF THE INTERIOR, WASHINGTON, D. C.

FROM THE CHIEF OF BUREAU OF LAND MANAGEMENT, DENVER, COLORADO

SUBJECT: [Illegible]

RE: [Illegible]

YOUR LETTER OF [Illegible]

IS RECEIVED AND THE MATTER IS BEING CONSIDERED.

VERY TRULY YOURS,

[Illegible Signature]

[Illegible Title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>KATHRYN</b>		First		Middle		Last		2a. DATE OF DEATH <b>Feb.</b> Month <b>12</b> Day <b>1968</b>		2b. HOUR <b>5:00</b> A
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 4, 1872</b>		6. AGE (In years last birthday) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>				10. M.D.
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Randolph Hills Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>309 Nimitz Ave.</b>		
14. FATHER'S NAME <b>Luther Buice</b>		First		Middle		Last		15. MOTHER'S MAIDEN NAME <b>Ellen Dufau</b>		First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <b>No</b>		(If yes give war or dates of service)		17. SOCIAL SECURITY NO. <b>057-42-1891-J1</b>		17. INFORMANT <b>Ava E. Ledford</b>		Address <b>Item # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <b>Cerebral Thrombosis</b>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <b>gn. arteriosclerosis</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<b>332x</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/13/1964</b> , to <b>2/10/1968</b> , that (I) (we) last saw the deceased alive on <b>2/10/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stephen N. Jones</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/12/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>		22e. ADDRESS <b>Rockville, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Atlanta, Georgia</b>				
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1321 Rock. Pike</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



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68  
16  
2  
D.C. cleared with Medical Examiner

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>NELLIE K REDMOND</b>			2a. DATE OF DEATH <b>Feb</b> Month <b>6</b> Day <b>1968</b>			2b. HOUR <b>12:15</b> M			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>12-11-96</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Auditor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8110 New Hampshire</b>	
14. FATHER'S NAME First Middle Last <b>----- Bowen</b>		15. MOTHER'S MAIDEN NAME First Last Middle Last <b>Isabelle Lanham</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>578-38-063</b>		17. INFORMANT <b>Mrs Eva Beckwith</b>		Address <b>Milwaukee, Wis</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>410.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>last</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 Hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? (PENDING) YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>approximately, 1963</b> , to <b>Feb 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gene U. Cohen M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Feb 6, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>GENE U. COHEN, M.D.</b>		22e. ADDRESS <b>1106 SPRING ST SILVER SPRING, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>2/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges County</b>			
24. FUNERAL DIRECTOR <b>S.H. Hines Co. Wash. D.C.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DATE FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> Md.			





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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Nathan			Reingold			February 13 1968			2:40 P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			7. IF UNDER 1 YEAR	
M		W		25 Jan '85			83 YRS.			MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Russia			USA						Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
90 Silver Spring			Cherry Chase Convalescent Home			Self employed			17410E		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
67 Maryland			Carroll			Baltimore			112 - Walnut		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
UNKNOWN			UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT					
NO			UNKNOWN			JACK B. REINGOLD, MD 9314 94th St. N.E. Wash					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4339 Respr. Centry										5 min	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Cerebral Thrombosis										5 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c) Generalized Arteriosclerosis										5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
332X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1965, 19, to 13 Feb, 1968, that (I) (we) last saw the deceased alive on 13 Feb 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Milton Gurdak M.D.						13 Feb 68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Milton Gurdak, M.D.						1100 - 22 NW Wash. Dr. Jan 37					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			2-14-68			Beth Abraham Cem.			Rosenhaym, N.J.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Goldberg Funeral Home 4217 9th Street NW						FEB 19 1968			Charles J. J...		

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]*



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
02894									
04422									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
GEORGE L. REUSS						Feb. 29, 1968			11:55 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Cauc.		Mar. 24, 1893		77 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Indiana		U. S.				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington Sanitarium			Supervisor			U.S. Gov't
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4400 East-West Highway
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
(Unknown) Reuss			Catherine Bogal						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes. WW I			579-60-9852		Wife Susie E. Reuss		Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u>									unknown
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u>									unknown
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pyelonephritis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Chronic Pyelonephritis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work					Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1967, to 3-1, 1968, that (I) (we) last saw the deceased alive on 2-29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Gilbert B. Cushner M.D.					3-1-68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Gilbert B. Cushner					11161 New Hampshire Ave. White Oaks, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3-4-68		National Mem. Park		Falls Church, Virginia		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland					DATE MAR 8 1968		[Signature]		



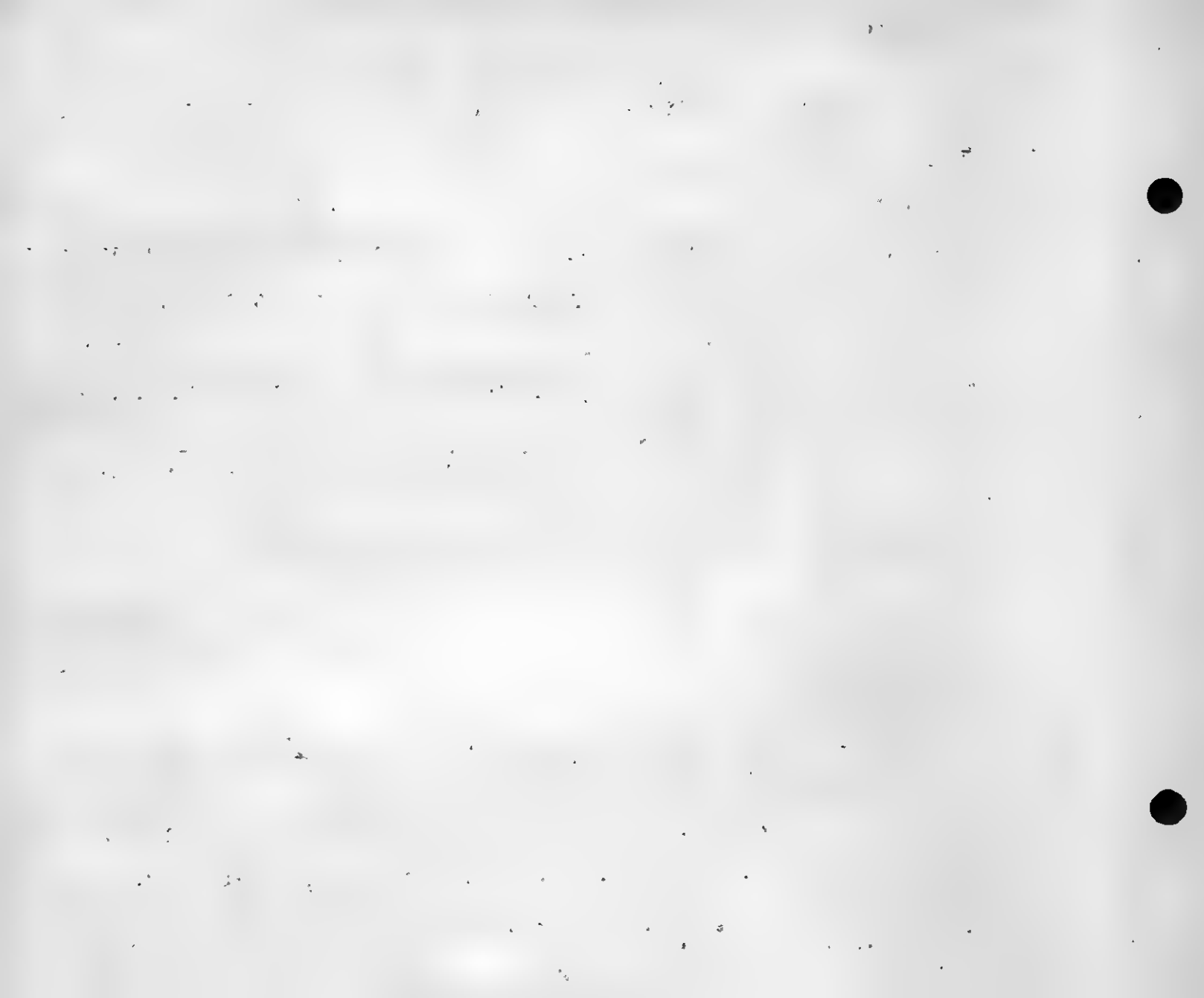
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2895

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>HELEN DOYLE RICE</b>			2a. DATE OF DEATH Month <b>FEB</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>1240PM</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>14 JAN 09</b>		6. AGE (In years last birthday) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTH-PLACE (State or foreign country) <b>WISCONSIN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSPITAL, BETH MD</b>				12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired) <b>PSYCHOLOGIST</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CIVIL SERVICE</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>HYATTSVILLE</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5023 59TH AVE.</b>			
14. FATHER'S NAME First <b>JAMES</b> Middle <b>JOSEPH</b> Last <b>DOYLE</b>			15. MOTHER'S MAIDEN NAME First <b>EMMA</b> Middle <b>BELL</b> Last <b>LANGE</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>577 36 1349</b>		17. INFORMANT Address <b>ROSEMARY BEALES 1837 MONROE ST. N.E. WDC</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF BREAST WITH WIDE-</b> <b>spread INVOLVEMENT OF LUNGS AND BONE MARROW</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>170x</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that <del>my</del> (this hospital) attended the deceased from <b>6 FEB</b> , 19 <b>68</b> , to <b>22 FEB</b> , 1968, that <del>my</del> (we) last saw the deceased alive on <b>22 FEB</b> , 1968, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>my</del> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Theodore H. Wilson, Jr. M.D.</b> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>22 FEBRUARY 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>TH EODORE H. WILSON, JR., M.D.</b>						22e. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington</b>				23d. LOCATION (City or Town) (County) (State) <b>Virginia</b>			
24. FUNERAL DIRECTOR <b>Gasch's Funeral Home</b> ADDRESS <b>4739 Baltimore Ave. Hyattsville, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 27 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

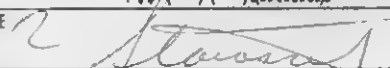

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR			
William E Rice						Month Day Year			2b HOUR			
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7c MONTHS		7d DAYS	
M			W.		July 29, 1897		70 YRS					
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH			
Ohio			U.S.A.			WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Chevy Chase			3708 Manor Rd			Retired-Engineer			Bureaus of Mines.			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d STREET AND NUMBER			
Md.			Montgomery			Bethesda			3708 Manor Rd			
14 FATHER'S NAME			15 MOTHER'S M.A.DEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			17 INFORMANT			
John Clarence Rice			Pearl Francis Grubb			No			Daughter Mrs. Henry Kirkpatrick			
16b SOCIAL SECURITY NO			17 ADDRESS			18			19			
			871 Somerset La York, Pa.									
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cardiac Tamponade - Sudden												
441.0 DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of Dissecting Aneurysm of Aorta Sudden												
Conditions, if any, which gave rise to immediate cause (a) DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Vascular Disease - years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
451x												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			P.M. 19									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED						
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
JOHN G. BALL						Feb. 5, 1968			Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2-9-68			Home Wood Cemetery			Pittsburgh, Penna.			
24. FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
ROBERT A. PUMPHREY, Bethesda, Maryland			DATE			FEB 13 1968						

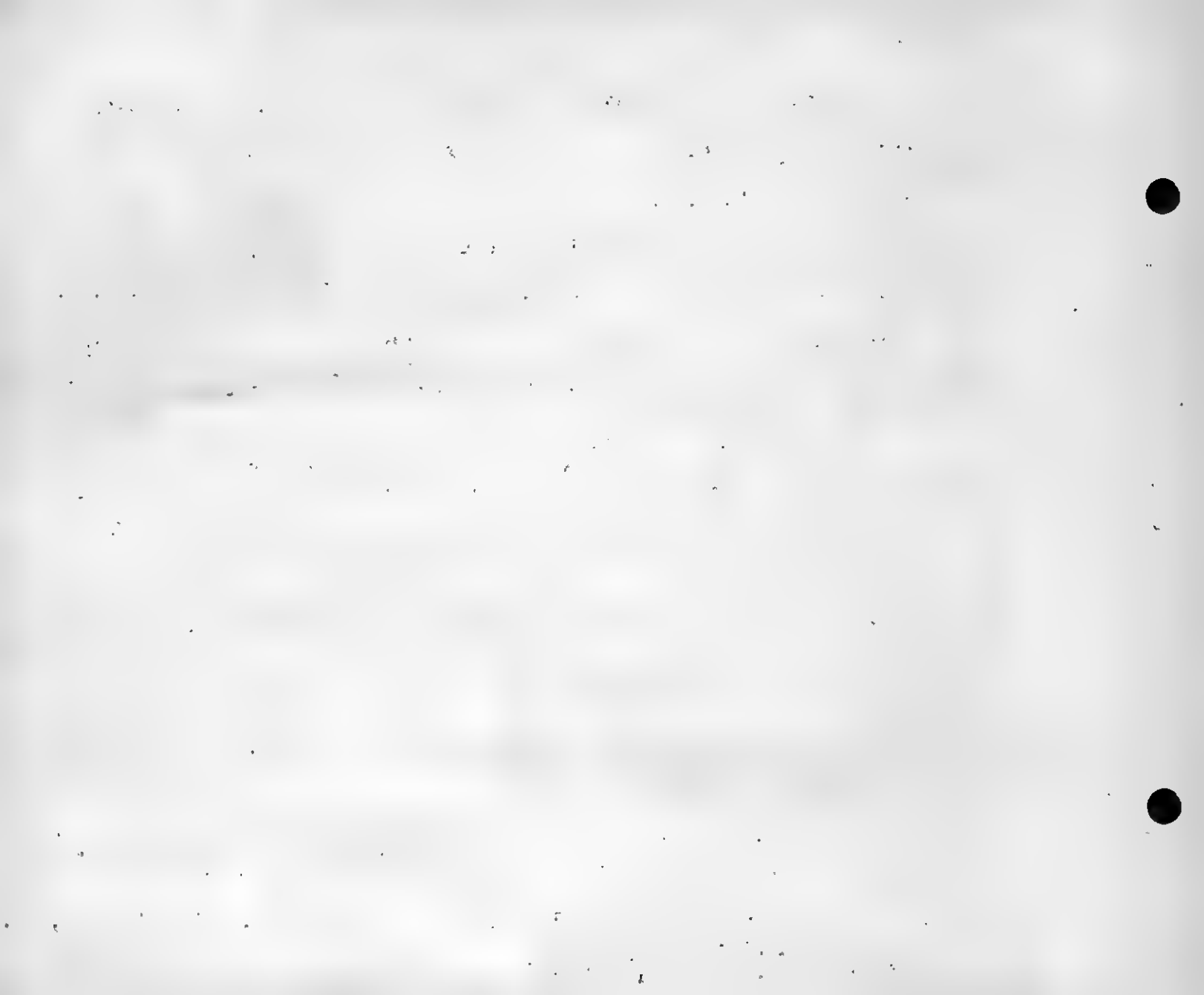
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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First <b>Anita</b>		Middle <b>Thersa</b>		Last <b>Rinaldi</b>		2a. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1968</b>		2b. HOUR P <b>1:30 M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>21 November 1907</b>			6. AGE (In years last birthday) <b>60</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Vermont</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.						
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address) <b>Washington, DC</b>			13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Wash., DC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2900 30th Street, S. E.</b>			
14. FATHER'S NAME First <b>Cornelius</b> Middle <b>Granai</b> Last <b>Elvira</b>			15. MOTHER'S MAIDEN NAME First <b>Elvira</b> Middle <b>Volpi</b> Last <b>Volpi</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-20-3962</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub acute bacterial endocarditis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Mitral valve replacement for</b> (b) <b>mitral stenosis and insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic heart disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>5 weeks</b> <b>46 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4.</b>												
19a. DATE OF OPERATION <b>18 Jan 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Mitral stenosis and insufficiency</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 17, 19 67</b> , to <b>Feb. 25, 19 68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 25, 19 68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.												
22b. SIGNATURE  DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>26 February 1968</b>						
22d. PHYSICIAN'S NAME (Type) <b>Rudolf N. Staroscik, MD</b>						22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>						
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>2/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Prince Georges, Md.</b>						
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b> ADDRESS <b>4308 Suitland Road, Suitland, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 29 1968</b>		25b. REGISTRAR'S SIGNATURE 				



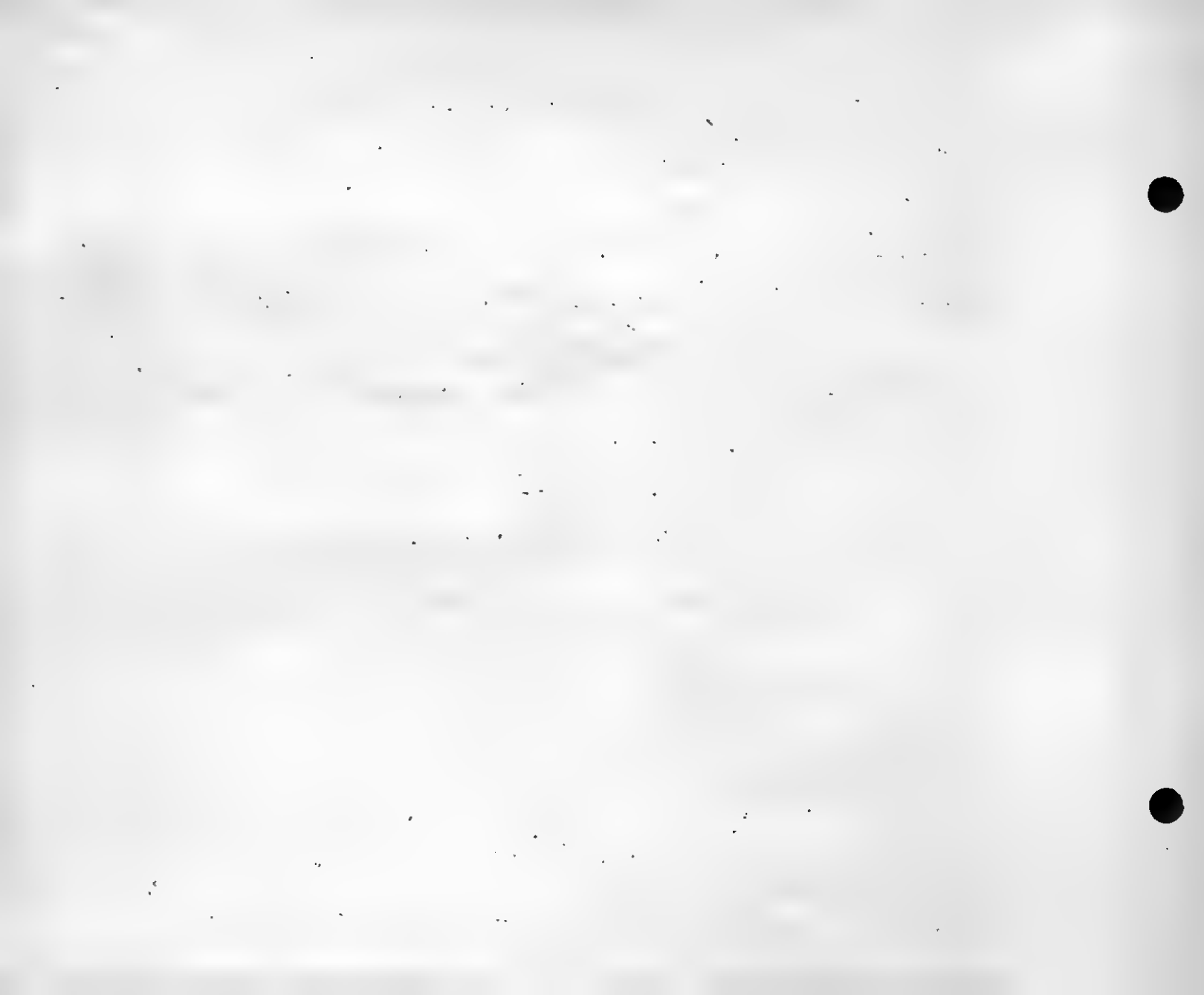
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Alex J. Raberick</i>			2a. DATE OF DEATH Month <i>Feb.</i> Day <i>2</i> Year <i>68</i>			2b. HOUR <i>6:30</i> AM											
3. SEX <i>M-</i>			4. RACE <i>CAUC.</i>			5. DATE OF BIRTH <i>8-31-15</i>			6. AGE (In years last birthday) <i>52</i> YRS.			IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>			IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>MD. VA.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.								
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Col. Ret. U.S.A.</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. ARMY</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. CITY OR TOWN <i>Montgomery</i>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>7803 Marion Lane</i>								
14. FATHER'S NAME First <i>ALEX</i> Middle <i>ROBERT</i> Last <i>LEE</i>			15. MOTHER'S MAIDEN NAME First <i>ROSE</i> Middle <i>LEE</i> Last <i>PRUETT</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>U.S. Army WWII</i>			16b. SOCIAL SECURITY NO. <i>219-34-9678</i>			17. INFORMANT <i>Mrs. Dorothy A. Raberick</i>			Address <i>same as above</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Emboli - bilateral</i> <i>157.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Thrombophlebitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Pancreas</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>12/21, 1967</i> , to <i>2/2, 1968</i> , that (I) (we) last saw the deceased alive on <i>2/2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Geo. A. Gray, M.D.</i>			22c. DATE SIGNED <i>2/2/68</i>			22d. PHYSICIAN'S NAME (Type) <i>Geo. A. Gray, M.D.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>2-6-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT. CEMETERY</i>			23d. LOCATION (City or Town) <i>ARLINGTON, VIRGINIA</i>			(County)			(State)		
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SONS, INC., WASHINGTON, D.C.</i>						25a. REC'D BY REGISTRAR DATE <i>FEB 8 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



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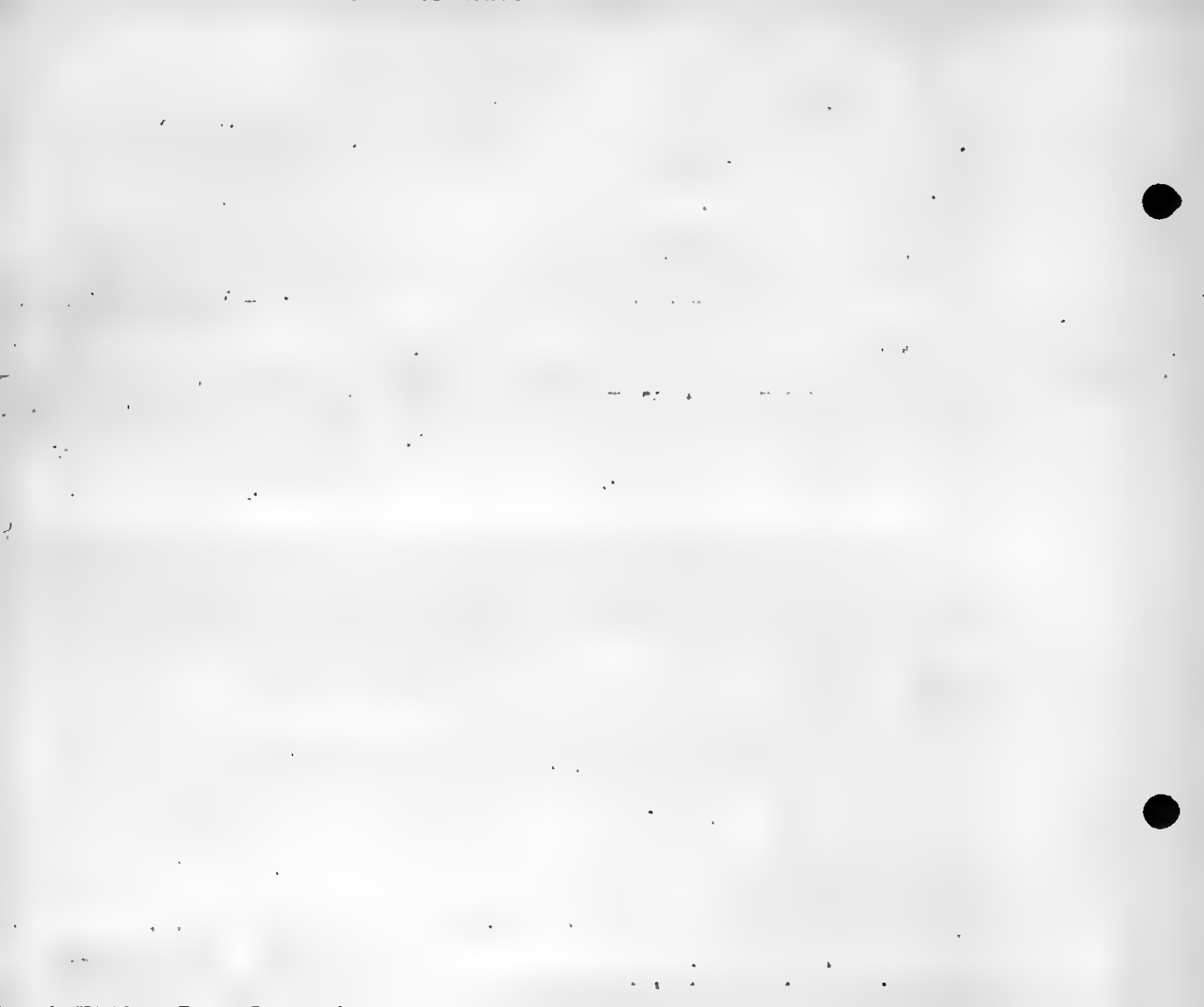
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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Anna Middle J. Last Rodgers			2a. DATE OF DEATH Month February Day 13, Year 1968			2b. HOUR 8:25 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 28, 1891		6. AGE (in years last birthday) 76 YRS	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3055 - 16th Street, N.W.	
14. FATHER'S NAME First Middle Last James Cullinan			15. MOTHER'S MAIDEN NAME First Middle Last Annie Weber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 158-09-3242B		17. INFORMANT Address Wm. J. Rodgers, Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aortic Aneurysm</u> 4' DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CV. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days YRS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 451 X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 10, 1968, to Feb 13, 1968, that (I) (we) last saw the deceased alive on Feb 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DeWitt E. DeLaater				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb 13, 1968	
22d. PHYSICIAN'S NAME (Type) DeWitt E. DeLaater				22e. ADDRESS 3848 Parker St N.W. Washington D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-16-1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 6130 Wisconsin Ave. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b. REGISTRAR'S SIGNATURE Richard J. Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

32900

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Thomas Stewart Rogers			2a. DATE OF DEATH Month Day Year February 10 1968			2b. HOUR A 7:33 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 2, 1917		6. AGE (In years last birthday) 50 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales Representative		12b. KIND OF BUSINESS OR INDUSTRY Baking			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4601 Powder Mill Road	
14. FATHER'S NAME First Middle Last Willie T. Rogers			15. MOTHER'S MAIDEN NAME First Middle Last Ella Powell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1945			16b. SOCIAL SECURITY NO. 5-79-03-3424		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Probable septicemia DUE TO, OR AS A CONSEQUENCE OF (c) Hodgkins Disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 hour 2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 10					
22a. I certify that (X) (this hospital) attended the deceased from January 2, 1968, to February 10, 1968, that (X) (we) last saw the deceased alive on February 10, 1968, and that in (NY) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE Arthur R. Ugel						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10 February 1968	
22d. PHYSICIAN'S NAME (Type) Arthur R. Ugel, M.D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-12-68		23c. NAME OF CEMETERY OR CREMATORY FT LINCOLN		23d. LOCATION (City or Town) (County) (State) WASH. D.C.			
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME				ADDRESS WALDORF, MD.		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 23b Film G398 2/29/68 kk CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Jeffery Thomas ROSS						February 14 1968			2:20 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		Cauc		13 February 1968			YRS 00		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital			Na			Na
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Na Md.			Na St. Marys			Na Lexington			13e. STREET AND NUMBER
									Na Rt. #1, Box 432-27C
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			Address			
First Middle Last			First Middle Last						
William J. ROSS			Doris K. PEARCH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
Na			Na		William J. Ross, Rt #1 Box 432 Lexington Pk. Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congenital Heart Disease									
DUE TO, OR AS A CONSEQUENCE OF									
Aortic Valve Atresia									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 13 Feb 1968, to 14 Feb 1968, that (I) (we) last saw the deceased alive on 14 Feb 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
G.P. SWARTZ					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			16 Feb 1968	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		2/19/1968		Arlington National			Arlington, Va.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
R.A. PUMPHREY, 7557 Wisconsin Ave Md.					DATE FEB 26 1968		Charles J. Jones		

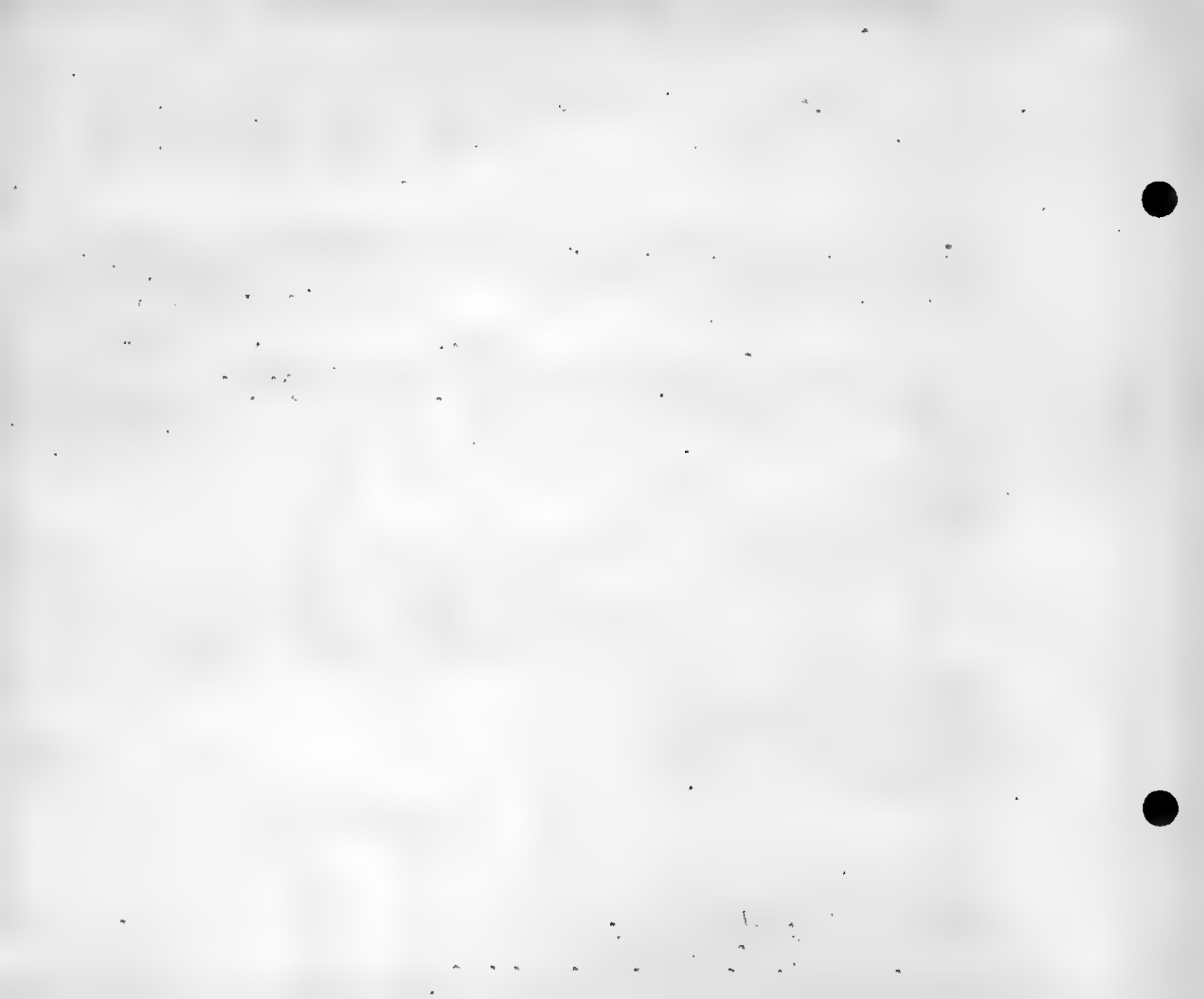


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Charged by Medical Examiner Dr. John Rep

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Lee Carol Rupert			2a. DATE OF DEATH Month Day Year 2/21/68			2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH M/P/V/ 5/19/67		6. AGE (In years last birthday) 9 mos yrs		7. UNDER 1 YEAR MONTHS DAYS 9 28	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b. KIND OF BUSINESS OR INDUSTRY N.A.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Mont/		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12300 Blakely Court	
14. FATHER'S NAME First Middle Last Gerald L. Rupert			15. MOTHER'S MAIDEN NAME First Middle Last XXXXXX Claire Sheaffer XXXXXX						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give year or dates of service) none		17. INFORMANT Silver Spring, Md. Gerald L. Rupert - 12300 Blakely Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden Death. 079.7 DUE TO, OR AS A CONSEQUENCE OF (b) Acute viral Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb. 20, 1968, to Feb. 21, 1968; that (I) (we) lost saw the deceased alive on Feb. 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ralph Stiller MD				22c. DATE SIGNED 2/21/68		22d. PHYSICIAN'S NAME (Type) Ralph Stiller			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George Co. Maryland		23e. REGISTRAR'S SIGNATURE Charles Jones	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sil. S. Md.				25a. REC'D BY REGISTRAR FEB 26 1968		25b. REGISTRAR'S SIGNATURE			





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VA 151 (M)  
304 REV 1-54

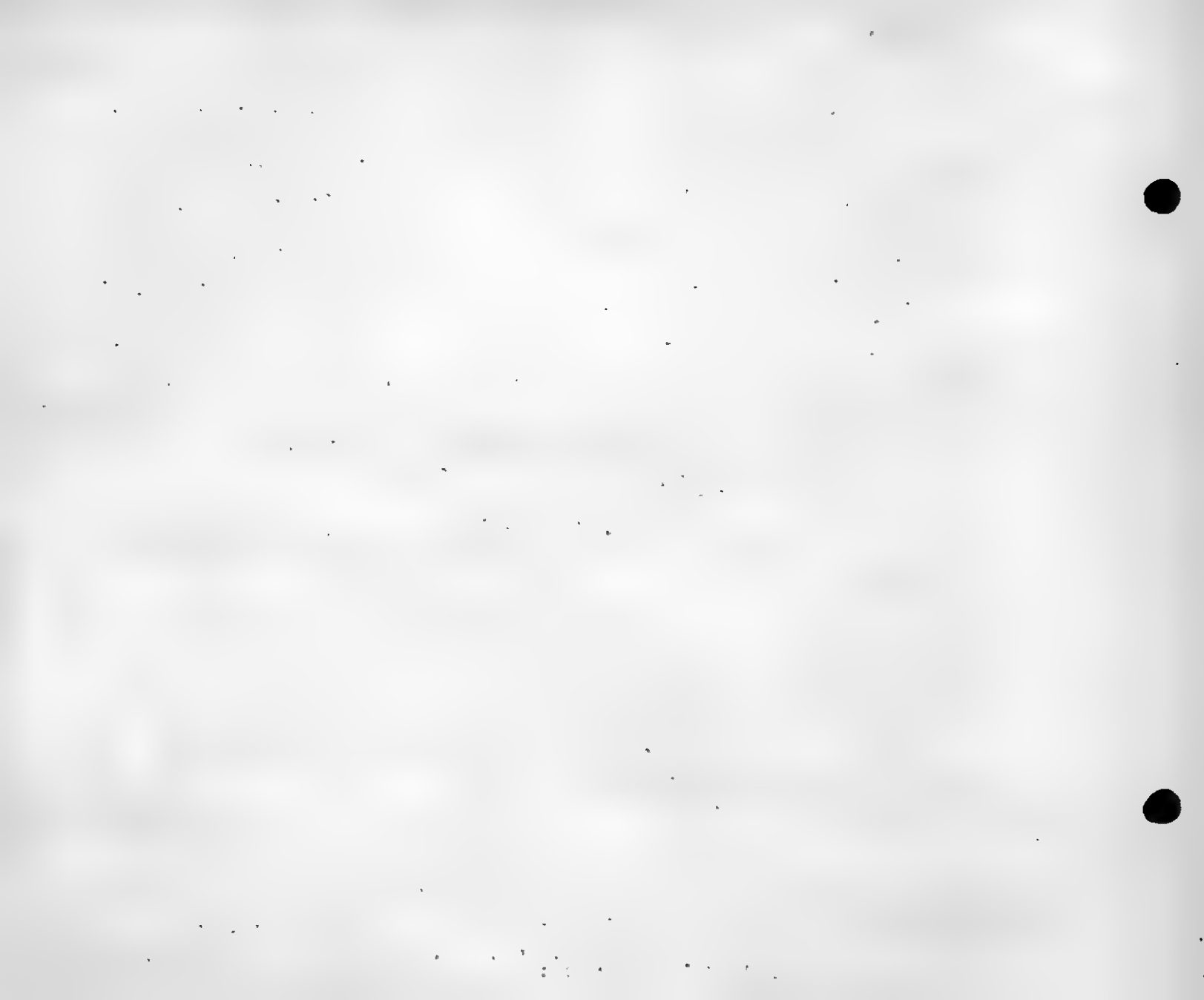
02903

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0288.1

1. DECEASED-NAME (Type or print) <i>Mary C. Ryan</i>			2a. DATE OF DEATH Month <i>February</i> Day <i>19</i> Year <i>68</i>		2b. HOUR <i>9:30 P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>2-29-76</i>		6. AGE (in years last birthday) <i>91</i> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Kensington</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4411 Brookfield Ave</i>	
14. FATHER'S NAME First <i>Peter</i> Middle <i>McKeon</i> Last <i>McKeon</i>	15. MOTHER'S MAIDEN NAME First <i>Mary G. Moore</i> Middle <i>Hoare</i> Last <i>Hoare</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. ---	17. INFORMANT Name <i>Michael J. Ryan - same</i> Address <i>See Item #13.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASPD -</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic obstructive pulmonary disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>4</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>2/6/68</i> , 19 <i>7</i> , that (I) (we) lost saw the deceased alive on <i>2/19/68</i> , 19 <i>7</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death					
22b. SIGNATURE <i>[Signature]</i>		22c. DATE SIGNED <i>2/19/68</i>		22d. PHYSICIAN'S NAME (Type) <i>[Signature]</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>2-23-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>	
23d. LOCATION (City or Town) (County) (State) <i>Laural, Md.</i>		24. FUNERAL DIRECTOR <i>Joseph Lawler's Sons, Inc.</i>		25a. REC'D BY REG. STRAR DATE <i>FEB 26 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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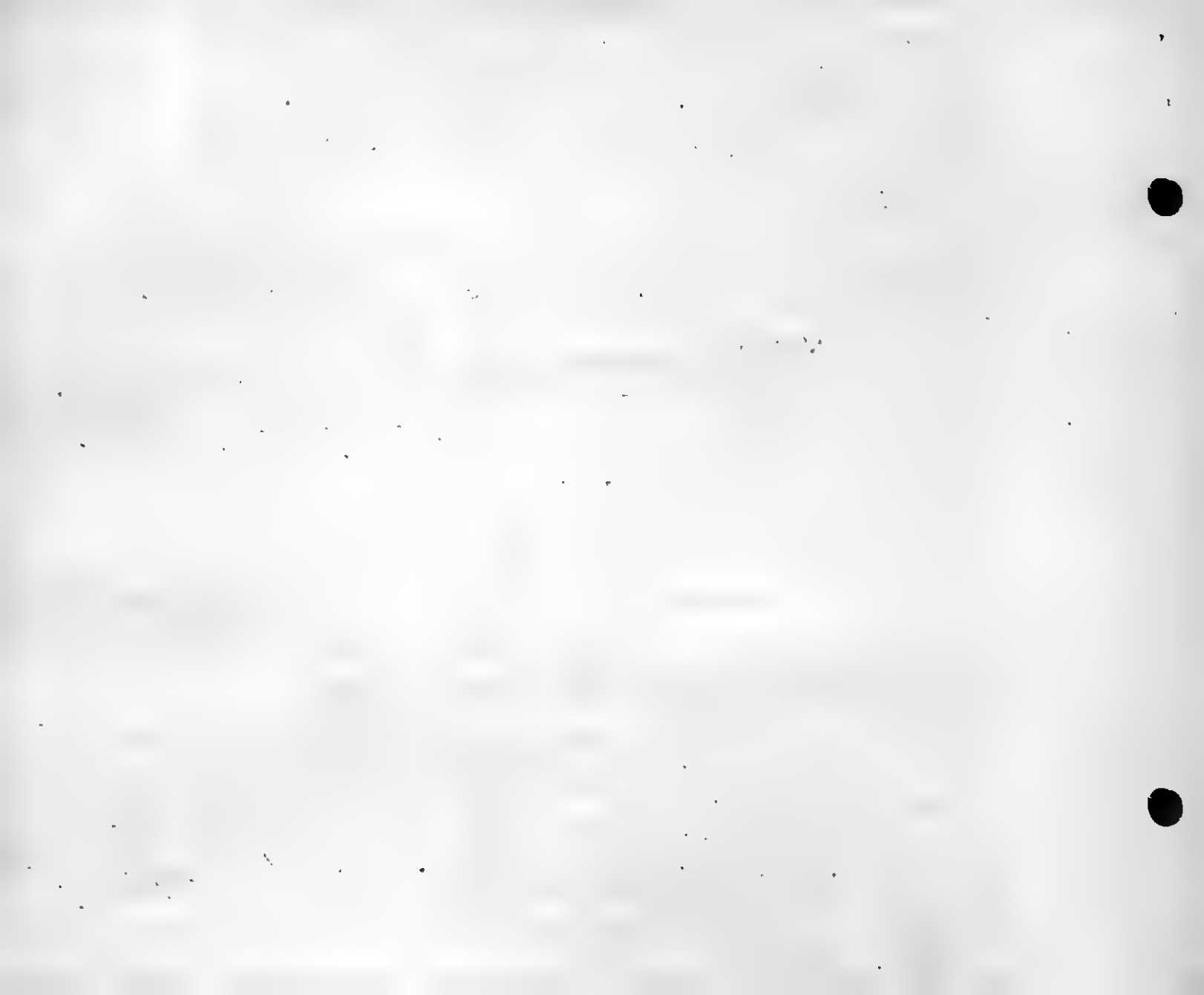
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Diane Elaine SANDERS			2a. DATE OF DEATH Month Day Year Feb. 2 1968			2b. HOUR 620 PM			
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH January 29, 1968		6 AGE (In years lost birthday) YRS. MONTHS DAYS 4		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Pensacola		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Florida		13b COUNTY Argyle		13c. INSIDE CITY LIM 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P. O. Box 93			
14. FATHER'S NAME First Middle Last James T. Sanders			15. MOTHER'S MAIDEN NAME First Middle Last Edith Elaine Milhorn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO. (If yes give war or dates of service) N/A		17 INFORMANT Hospital records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease; pulmonary valve stenos 1467 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 125									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Feb. 1, 1968, to Feb. 2, 1968, that (1) (we) last saw the deceased alive on Feb. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gene P. Swartz, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Feb. 5, 1968			
22d. PHYSICIAN'S NAME (Type) Gene P. SWARTZ, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-8-68		23c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery		23d. LOCATION (City or Town) (County) (State) De Funiak, Florida			
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda				25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Edward L. Schlein						Feb. Month 8 Day 68 Year		1:30 PM			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
Male		White		2-2-68X 9-7-91		76 XX YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Montgomery Md					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville			Montgomery General			Salesman					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
STATE Maryland			Carroll		Sykesville		YES <input type="checkbox"/> NO <input type="checkbox"/>		146 Second St.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Henry P. Schlein						Lena					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes, no, or unknown			213-05-4968			Montgomery General Hospital			Olney, Md.		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>									2 days		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HSCVD</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-6-68</u> to <u>2-8-68</u> , that (I) (we) last saw the deceased alive on <u>2-7-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS		22c. DATE SIGNED	
<u>Frederick Moomau</u>								<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		<u>2-8-68</u>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Dr. Frederick Moomau						<u>Medical Center, Sandy Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL		2-12-1968		Loudon Park Cemetery			Baltimore, Maryland				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard, 4107 Wilkens Ave. 21229								FEB 13 1968			





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02906

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

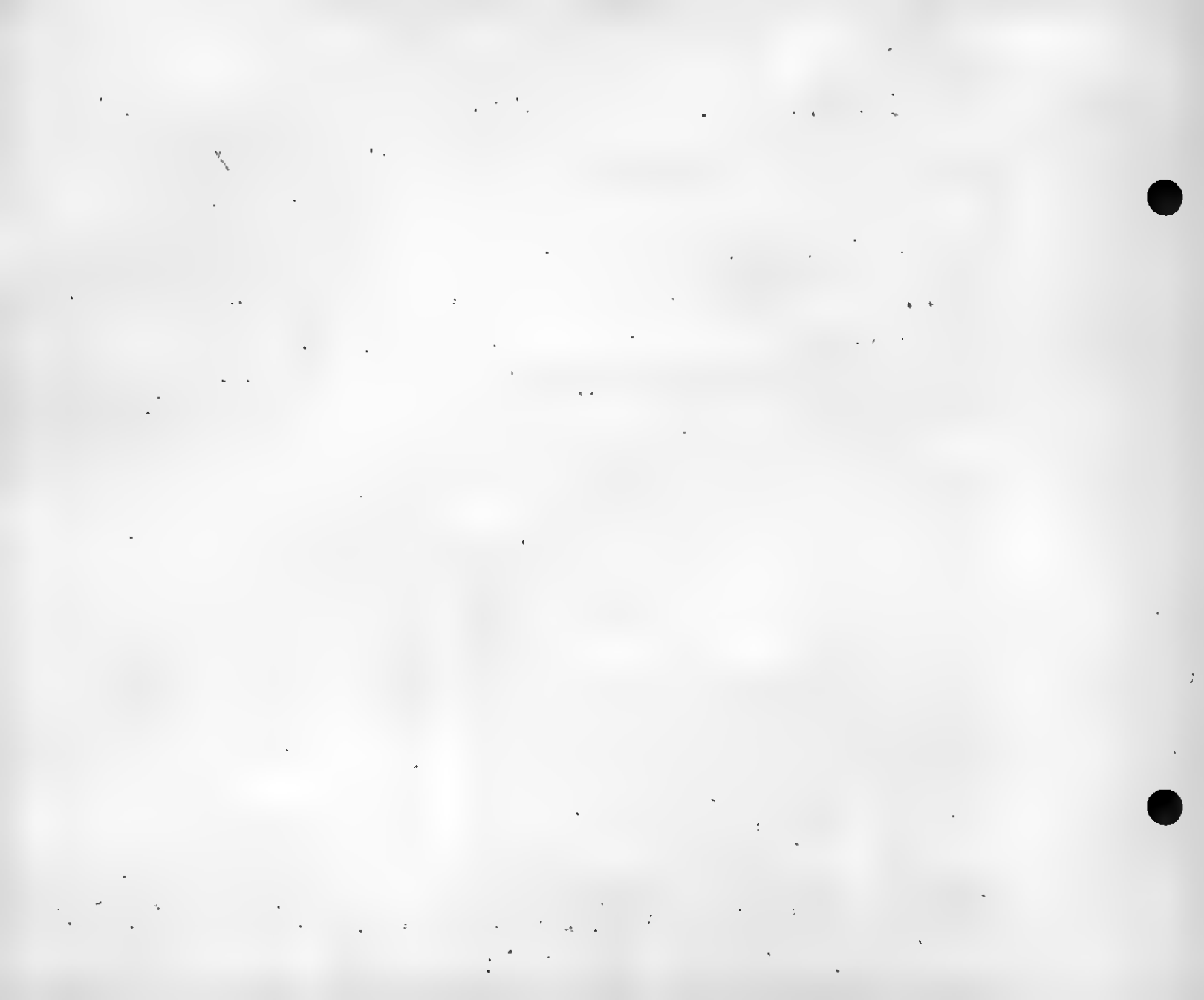
1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Virginia Elizabeth Schucht					MATED <input checked="" type="checkbox"/> 2 12 1968					L:35A
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. UNDER 1 YEAR		8. IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
F	W	2-11-1910		58	MONTHS DAYS HOURS MIN		Month Day Year		2d HOUR	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Milwaukee, Wis.		U. S. A				Montgomery		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Rockville		10201 Grosvenor Place		Housewife		None				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10201 Grosvenor Place		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME								
First Middle Last		First Middle Last								
William Dalhke		Ella Henke								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
No		394 28 5549		Gilbert M. Schucht Rockville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Breast with metastasis										8 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
17										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Dr. John G. Ball, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 2-12-68
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		2-12-68		Cedar Hill Crematory		Suitland Montgomery Md.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert A. Pumphrey 7557 Wisconsin Ave. Bethesda, Md.				DATE FEB 19 1968		Charles Judge				



Dr. Reap gave permission

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR	
ERSKINE LOWRY SCOTT						Month 2 Day 1 Year 68		10 <sup>10</sup> AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7 YEARS	
M		W		10-1-1890		77 1/2			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. VA.						MONTGOMERY Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK			WASH. SAN. + HOSP.						
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND			MONTGOMERY			TAKOMA PARK		7012 CARROLL AVE.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Last
SAMUEL					SCOTT	CELESTIA B.			THAVIS
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT		Address	
			218-70-1946			GLAAYS T. SCOTT		7128 CARROLL AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Cerebral anoxia									
41 } DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Coronary artery disease									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
4101									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1965, to Nov 17, 1967, that (I) (we) last saw the deceased alive on Nov 17 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Edward J. Richards						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Feb 3-1968					Largest Washington Cemetery		Largest, S. Bal. Md		
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR	
Arthur Walters						254 Carroll Ave		FEB 5 1968	
								25b. REGISTRAR'S SIGNATURE	
								[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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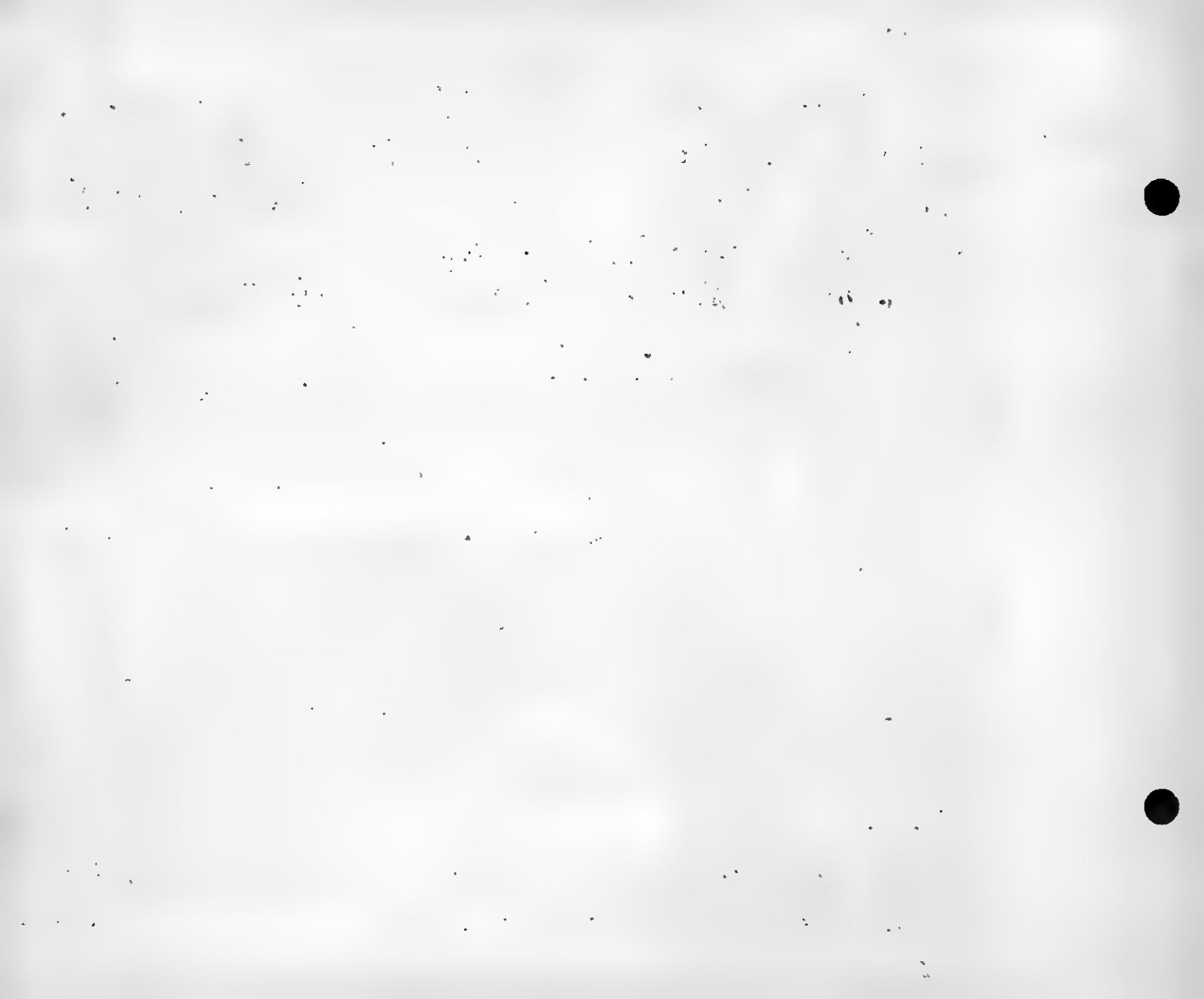
VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <b>Mary ANN SCOTT</b>			2a. DATE OF DEATH Month Day Year <b>02-21-68</b>		2b. HOUR <b>2A. M.</b>
3 SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>10-18-98</b>		6. AGE (In years last birthday) <b>69</b> YRS	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Sanitarium Hosp.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>MONTGOMERY-Silver Spring</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIM. TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>816 Univ. Blvd. E.</b>	
14. FATHER'S NAME First Middle Last <b>Fred Compter</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>Carline FOX</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>213-54-8195</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>7600 Carroll Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia + Inanition</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized metastases, secondary</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>to recurrent adenocarcinoma left breast</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>2 years</b>					
PART 2-OTHER-SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>170</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> No L. while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office-building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town. County. State	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-1-68</b> , 19 <b>68</b> , to <b>2/20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-20-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C. Shorrock M.D.</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/21/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>C. Shorrock M.D.</b>		22e. ADDRESS <b>811 N. W. Drive Silver Spring, MD 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Feb. 24, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Elmhurst. Prince Georges</b>	
24. FUNERAL DIRECTOR <b>Charles E. Walters</b>		25a. REC'D BY REGISTRAR <b>Charles E. Walters</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Walters</b>	

DATE FEB 23 1968



FOR STATE  
HEALTH DEPT.

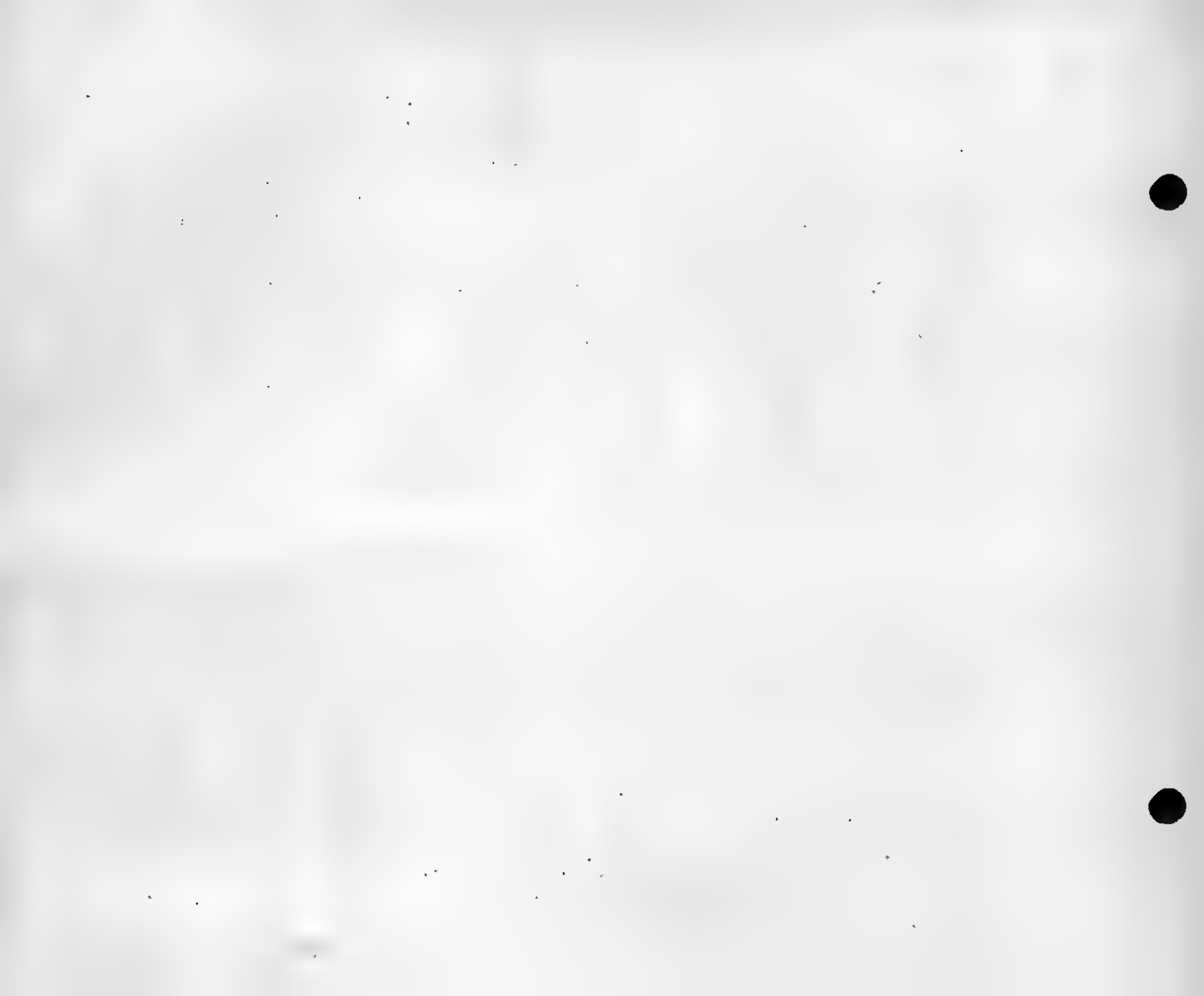
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

199 3-29-68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12885

1. DECEASED-NAME (Type or Print) <b>Richard Aiton Secord SR.</b>		First		Middle		Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>2</b> Day <b>3</b> Year <b>1968</b>		2b. HOUR <b>2:00</b> PM	
3 SEX <b>M</b>	4 RACE <b>W</b>	5. DATE OF BIRTH <b>9-4-1908</b>		6 AGE (In years last birthday) <b>59</b> YRS		7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN		2c. DATE PRONOUNCED DEAD Month <b>2</b> Day <b>3</b> Year <b>1968</b>		2d. HOUR <b>2:00</b> PM	
7a. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH. SAN. &amp; Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>O. S. I.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FED GOVT</b>		
13a. SLA. RESIDENCE (Where deceased lived, if institution residence before admision) STATE <b>MD</b>		13b. COUNTY <b>PR. GEO.</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2207 LEWISDALE</b>			
14. FATHER'S NAME First <b>RICHARD A.</b> Middle <b>A.</b> Last <b>SECORD</b>		15. MOTHER'S MAIDEN NAME First <b>GERTRUDE</b> Middle <b>NOT AVAILABLE.</b> Last <b>NOT AVAILABLE.</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>320 10 3391</b>		17. INFORMANT ADDRESS <b>MRS Ann Secord - WIFE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound of chest with exsanguination</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last</b> (c) <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>1-15</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year <b>1:15 P.M. 2 3 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Deceased shot in Thorax by son</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>Hyattsville Pr. Geo M</b>		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Feb. 3, 1968</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>30.7.1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Calverley Manor Pr. Geo Co. MD</b>		County		State	
24. FUNERAL DIRECTOR <b>Arthur Klatte</b>		ADDRESS <b>254 Cornell St NW - DC</b>		25. RECEIVED BY REG. STRAIP <b>Feb 5 1968</b>		25b. REG. STRAIP'S SIGNATURE <b>Charles Judge</b>					



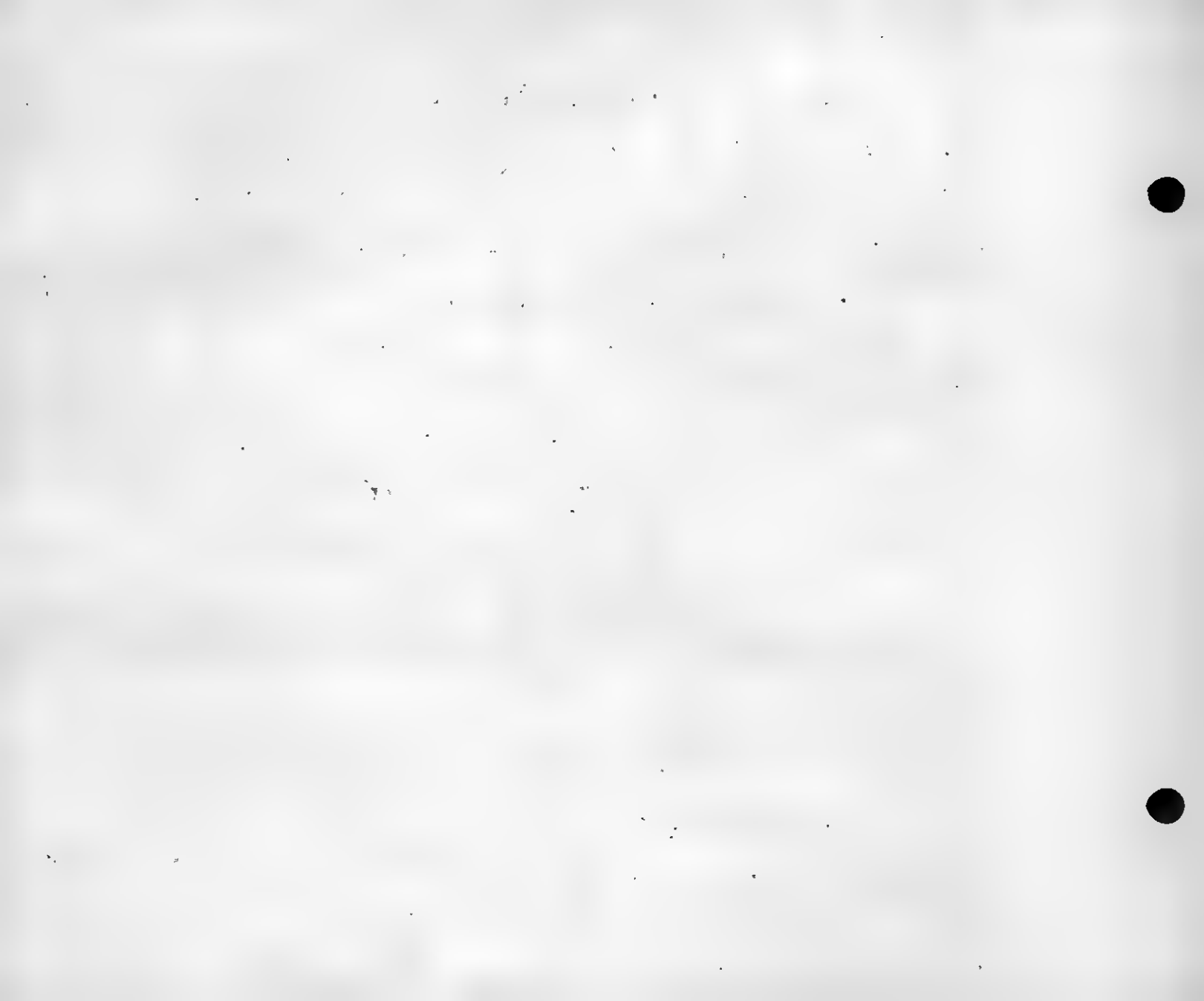


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. (M) 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										2896	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
SAMUEL ISRAEL SEMEL						X 2 29 1968			10 30		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD			2d HOUR		
M	W	2-19-95	73 YRS			2 29 1968			10 30		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
POLAND		USA				MONTGOMERY					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK			WASH SAN & HOSP.			PHOTOGRAPHER					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MD			MONTGOMERY			SILVER SPRING			8802 GLENVILLE RD APT 1		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
MORRIS SEMEL			CLARA SEMEL								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						DAUGHTER					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201 Diabetes Mellitus</u>											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21a TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City or town or county)			2/29/1968		
Belden R. Reap			M.D.								
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			March 1, 1968			King David Memorial Garden			Falls Church, Virginia		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Donald M. Stein			232 Carroll St., N.W., Wash., D.C.			MAR 4 1968			Charles Judge		
New Memorial Funeral Home											



02911

02891

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>5 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>				d. STREET ADDRESS <u>14108 Heritage Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Betty (NAN) Shuster</u>				4. DATE OF DEATH Month Day Year <u>2 4 1968</u>			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1898</u>		9. AGE (In years last birthday) <u>70</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Schrebrank</u>				14. MOTHER'S MAIDEN NAME <u>UNK.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>S.S. Md.</u> <u>ABE Shuster (son) 14108 Heritage Lane</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Recurrent pyelitis-urinary infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <u>NOS.</u> <u>YRS.</u> <u>NOS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1967, to <u>FEB. 4</u> , 1968 that (I) (we) last saw the deceased alive on <u>FEB. 3</u> , 1968, and that death occurred at <u>5:00</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Albert H. Grollmann</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>2/4/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMANN</u>				22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-5-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>HYATTSTVILLE, Maryland</u>	
24. FUNERAL DIRECTOR <u>Bernard Manzansky &amp; Sons</u> <u>3501-14th St. NW Washington, D.C. 20010</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

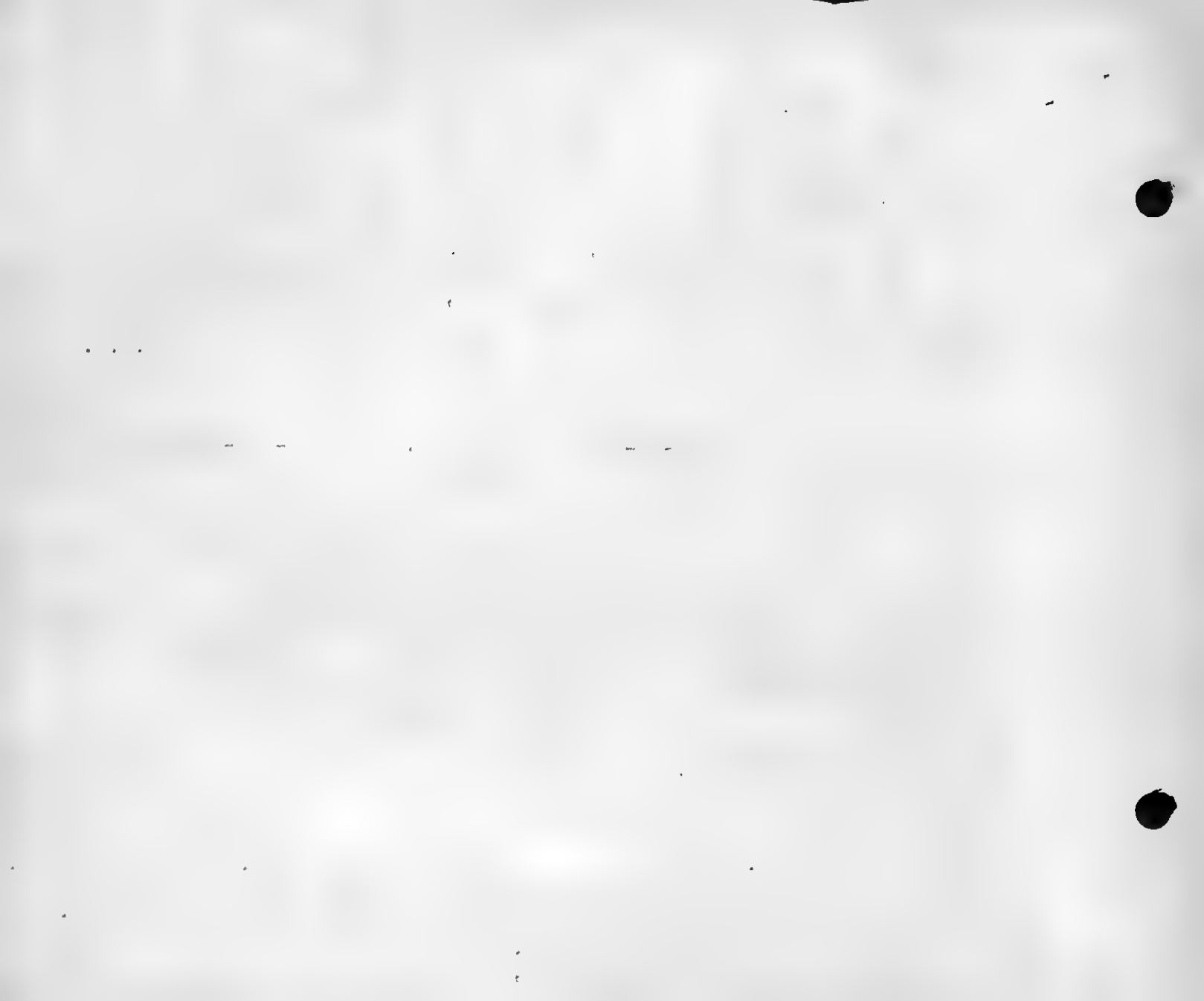
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

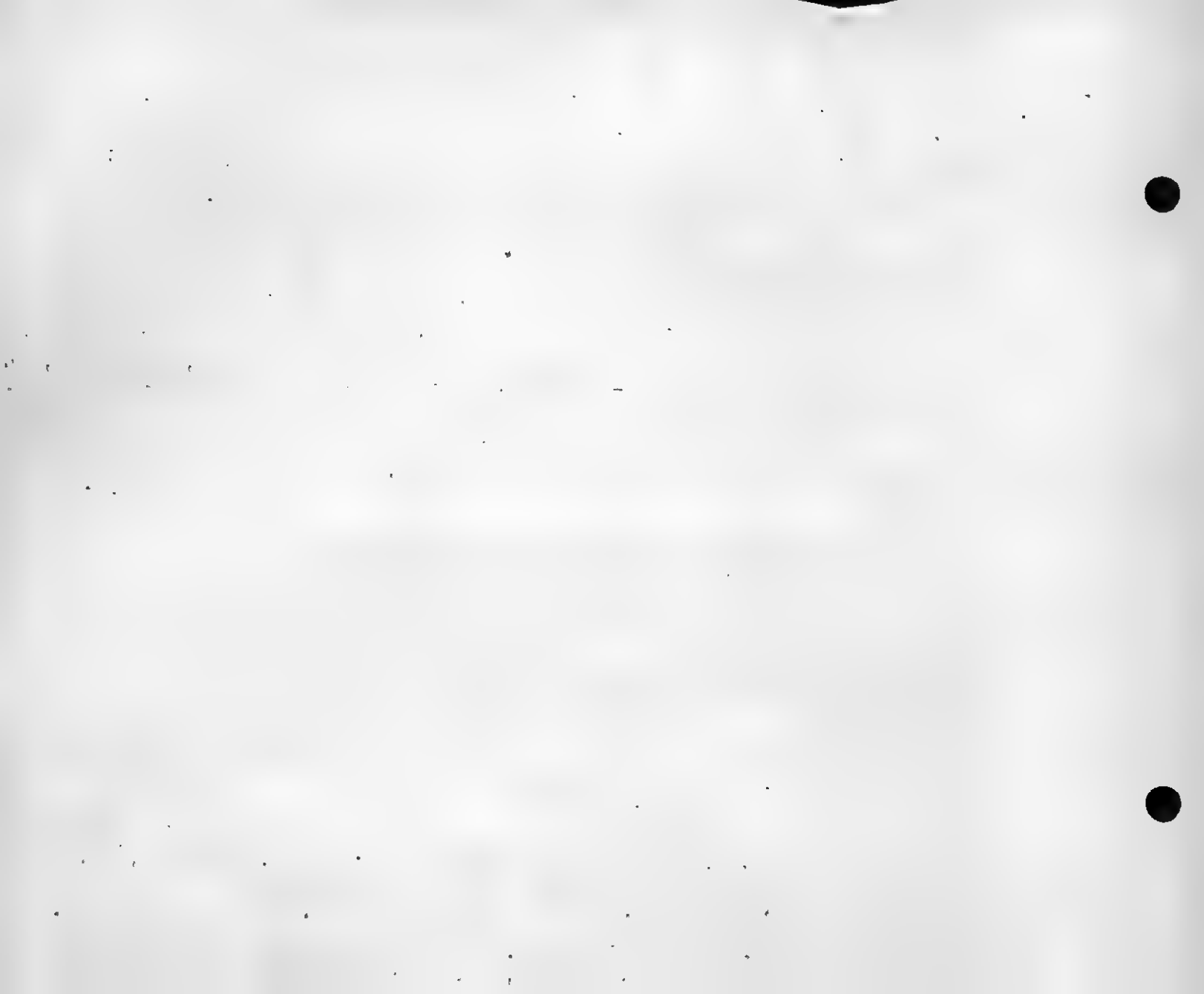
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3606 Farragut Street</b>						d. STREET ADDRESS <b>3606 Farragut Street</b>					
3. NAME OF DECEASED (Type or print) First <b>Bernice</b> Middle <b>S.</b> Last <b>Silbert</b>						4. DATE OF DEATH Month <b>Feb</b> Day <b>2</b> Year <b>1968</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1883</b>		9. AGE (In years) Last birthday <b>84</b> yrs. Months <b>8</b> Days <b>27</b> Hours <b></b> Min. <b></b>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank Wills</b>						14. MOTHER'S MAIDEN NAME <b>Susan Smullen</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>64-05-1697-D</b>		17. INFORMANT Address <b>Donald T. Silbert -son- item # 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>436.7</b> <b>Heart and vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerosis</b> DUE TO (c) <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>58</b> to <b>Feb 2</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1-31</b> 19 <b>68</b> , and that death occurred at <b>3:25</b> M., from the causes and on the date stated above.											
22a. SIGNATURE <b>John S. Rogers</b> M.D.						22b. DATE SIGNED <b>Feb 2, 1968</b>					
22c. PHYSICIAN'S NAME (Type) <b>John S. Rogers</b>						22d. ADDRESS <b>1919 Seminary Road, Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Whitemarsh Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Prospectville Pa.</b>		
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>						ADDRESS <b>Funeral Home 1331 Rock. Pike</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
						Rockville, Maryland					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month 2 Day 23 Year 68		2b. HOUR 8:15 AM	
3 SEX Female			4 RACE white		5. DATE OF BIRTH 6/23/04		6. AGE (In years lost birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS 5 DAYS 0
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Resmor Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10212 Rockville Pike	
14 FATHER'S NAME John			First	Middle	Lost	15 MOTHER'S MAIDEN NAME Mary		First	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 201-01-9736A		17. INFORMANT P. Usher, Rockville, Md. Nicholas Uhal-brother in law-10212 Rock.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 115X Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anaplastic carcinoma, thyroid gland/lymph nodes. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 194X Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 2/22, 1968, to 2/23, 1968, that (I) (we) last saw the deceased alive on 2/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George H. Mitchell MD				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/23/68	
22d. PHYSICIAN'S NAME (Type) George H. Mitchell				22e. ADDRESS 4890 Battery Lane, Bethesda, Md.					
23a. BURIAL, CREMATION, BURNAL (Specify)		23b. DATE 2/26/68		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City or Town) Uniontown		(County)	(State) Pa.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rock. Pike Rockville, Md.		25a. REC'D BY REGISTRAR FEB 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	





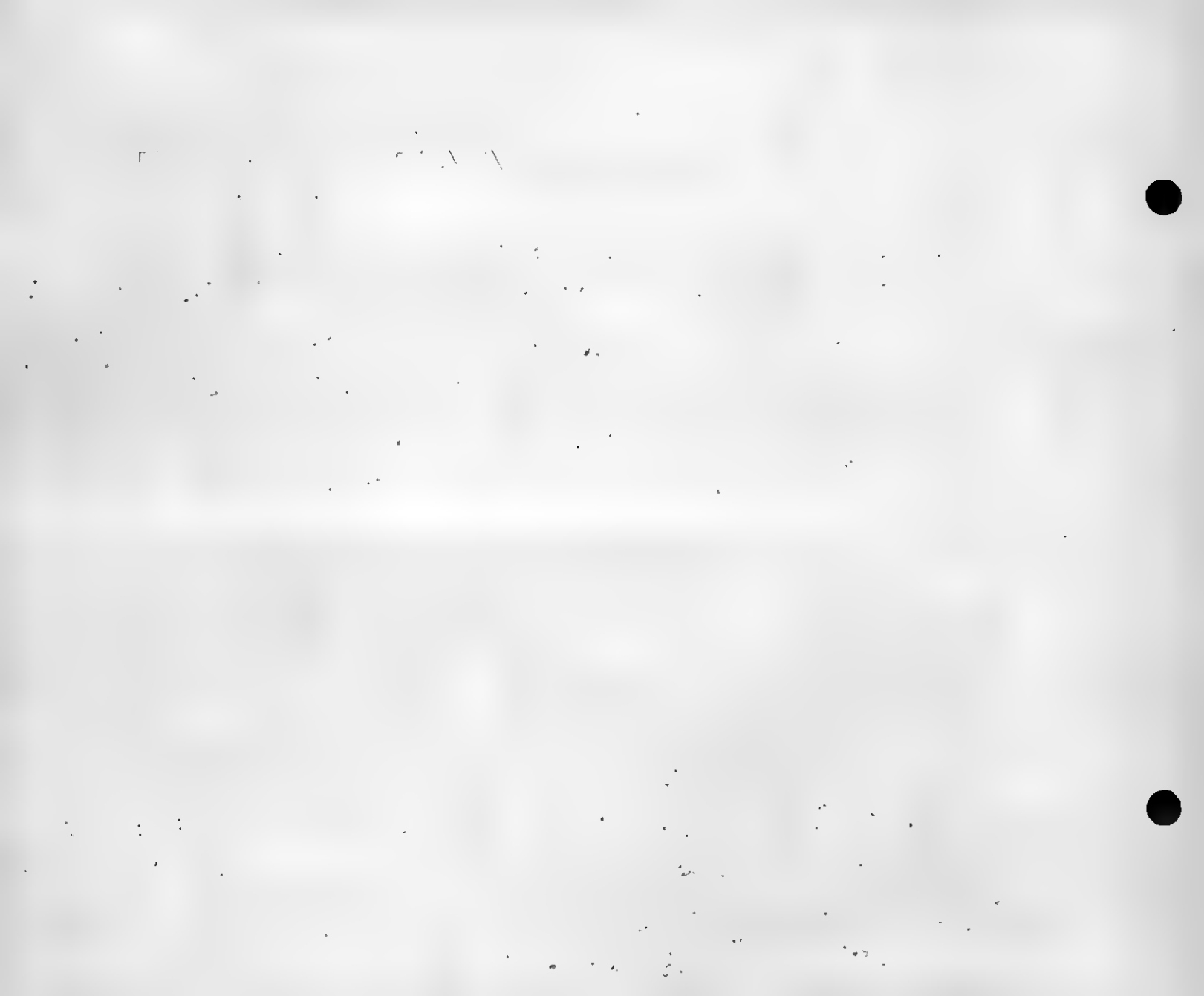
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>BERTHA E SMILEY</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>10</b> Year <b>68</b>			2b. HOUR <b>6<sup>15</sup> A.M.</b>	
3. SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>3/10/1881</b>		6 AGE (In years lost birthday) <b>86</b> YRS.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTWOOD NURSING HOME</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>D.C.</b>		13b COUNTY <b>—</b>		13c CITY OR TOWN <b>WASH.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>2323 - 40<sup>th</sup> PLACE, NW</b>		14 FATHER'S NAME First <b>NEILS</b> Middle <b>W.</b> Last <b>HOWSON</b>		15. MOTHER'S MAIDEN NAME First <b>SARAH</b> Middle <b>—</b> Last <b>HOWSON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)	
16b SOCIAL SECURITY NO.		17 INFORMANT <b>MR. EDWARD AYRE - 7302 - DURBIN TERR.</b>		Address <b>BETHESDA, MD.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> <b>H109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>4</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-4</b> , 19 <b>68</b> , to <b>2-10</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-8</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.C. Kirchner M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-10-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>R.C. KIRCHNER M.D.</b>		22e. ADDRESS <b>6480 N.H. Ave TAKOMA PARK, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>FEB. 13 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND MARYLAND</b>	
24. FUNERAL DIRECTOR <b>WILLIAM M. HYSONG</b>		ADDRESS <b>WASH., D.C.</b>		25a. RECEIVED BY REGISTRAR <b>FEB 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>11</b>	
HYSONG FUNERAL HOME - 1300 - N ST. N.W.							



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2a File # 6398 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 2/29/68 <b>6398</b> MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST- DEATH MATED			Month Day Year			2b HOUR			
Elizabeth			HANNAH			Smith			2			16 19 68			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD		2d HOUR	
Female		White		Sept. 12, 1886		81 YRS						February 16		6 12 A.M.	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Raleigh, N.C.			U. S. A.						Montgomery						
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK				Washington San. & Hospital				hswf							
13a USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY, IN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland				Prince George				Hyattsville				630 Sheridan St.			
14. FATHER'S NAME				15 MOTHER'S MAIDEN NAME											
First Middle Last				First Middle Last											
HENRY				BARBEE				HANNAH				SHANE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS			
No				579-28-8313				DAUGHTER: BERNADINE MORELAND				13916 dc			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))															
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 41: Acute Coronary Insufficiency															
DUE TO, OR AS A CONSEQUENCE OF, (b) Arteriosclerotic Heart Disease															
DUE TO, OR AS A CONSEQUENCE OF, (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION															
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
CAUSE OF DEATH				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				2 f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED							
Belden R. Peep								2/16/1968							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER											
BELDEN R. PEEP, M.D.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				19 Feb. 1968				Maine Street Cemetery				Washington D.C.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
RINALDI FUNERAL HOME INC.				1400 GEORGIA AVE. N.W. 20002				DATE FEB 19 1968				J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2916

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02901

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>3 YRS</u>		d. STREET ADDRESS <u>5608 BEAM CT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5608 BEAM CT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles HARRY</u> Middle <u>ELLIS</u> Last <u>SNOOK</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>16</u> Year <u>1968</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JUNE 19, 1886</u>
<b>9. AGE</b> (In years last birthday) <u>81</u> yrs		<b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MANAGERIAL</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SHOE STORE</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTIMORE, MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>HENRY MADISON SNOOK</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>SUSAN TRAVELS</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>YES</u> (If yes, give year or dates of service) <u>WWI</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-03-8287</u>	
<b>17. INFORMANT</b> <u>DAUGHTER</u>		Address <u>5608 BEAM CT Bethesda, MD</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>50X</u> DUE TO <u>carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of esophagus</u> DUE TO <u>carcinoma of esophagus</u> (c) <u>carcinoma of esophagus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>AUG 1967</u> <u>AUG 1967</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>SEPT</u> <u>1967</u> , to <u>FEB 16</u> <u>1968</u> , that I last saw the deceased alive on <u>2/15</u> <u>1968</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Robert S. Poole</u> M.D. <u>4501 CONN. AVE. NW</u> <u>2/16/68</u>		<b>DATE SIGNED</b>	
<b>PHYSICIAN'S NAME (Type)</b> <u>Robert S. Poole</u> <u>WASH. D.C.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Entombment</u>		<b>22b. DATE THEREOF</b> <u>2-19-68</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lorraine Park</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Baltimore</u> (State) <u>Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd., Balto.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>FEB 19 1968</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles J. Jager</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
BENJAMIN					SNYDER	Feb. 16 68			3:00 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 24 HRS. MONTHS DAYS HOURS M.N.		
MALE		CAUC.		10 - 1889		78 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
BALT. MD.		USA				MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
SIL. SPR. MD.			FAIRLAND NURSING HOME			INVESTOR		FINANCE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			BALTIMORE		PIKESVILLE		YES		133 SLADE AVE. HOUSE	
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last	
MORRIS					SNYDER	UNK.				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO			17. INFORMANT Address				
UNK.			579-60-3290			T. HOSP. HOME CHART -				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4129 Congestive Heart Failure</u>									2 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC Heart Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
7 x 2										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>68</u> , to <u>2/16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>R.T. Benack MD</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/16/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>R.T. Benack MD</u>						22e. ADDRESS <u>4455 Colie Dr. Wheaton, Md.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2/18/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH, VA.</u>				
24 FUNERAL DIRECTOR <u>Golding Funeral Home</u> ADDRESS <u>4217-9th St. N.W.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 21 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATE ON

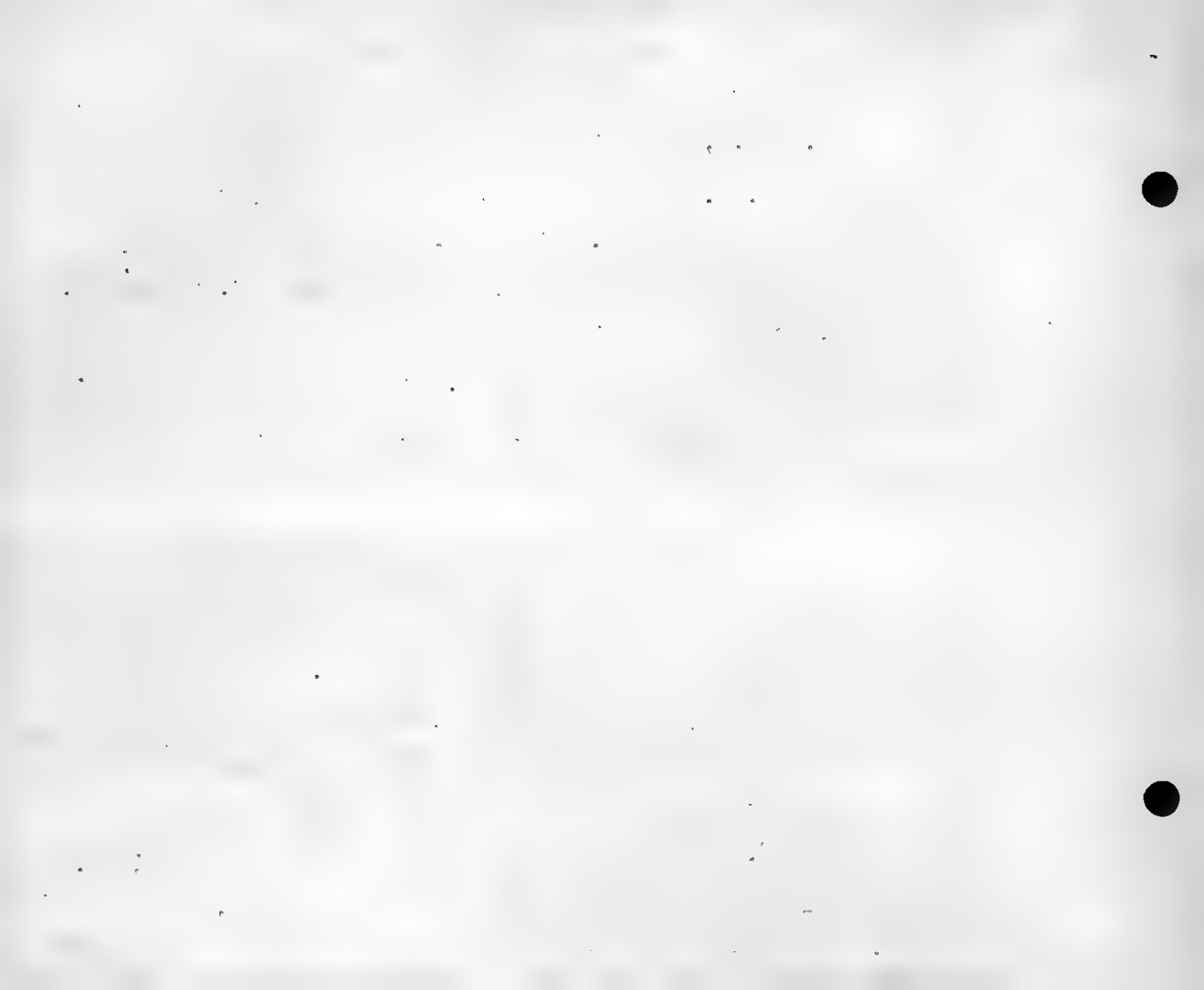




FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First JOHN COOPER SNYDER			Middle SYNDER			Last Snyder		
2a DATE KNOWN OF ESTI DEATH MATED		<input checked="" type="checkbox"/> Feb 8.		1968		2b HOUR 24		M			
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH Jan. 8, 1948		6 AGE (in years birthday) 20		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U. S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Kensington				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10004 E. Bexhill Dr.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Employee - Lumber Co.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b COUNTY Montgomery				13c CITY OR TOWN Kensington			
14 FATHER'S NAME John M. Snyder				15 MOTHER'S MAIDEN NAME Ann Cooper				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b SOCIAL SECURITY NO Unknown				17 INFORMANT Father John M. Snyder				18 ADDRESS Same as Item 10.			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shot Gun wound of head self inflicted DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 203 Feb 8 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self in head with shot gun			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No City or Town County State 10004 E Bexhill Dr Kensington Montgomery Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN G. BALL				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bethesda, Md.				22b DATE SIGNED Feb 8, 1968			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE 2-10-68		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d LOCATION (City or Town) (County) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a RECEIVED BY REGISTRAR DATE FEB 14 1968		25b REGISTRAR'S SIGNATURE [Signature]			

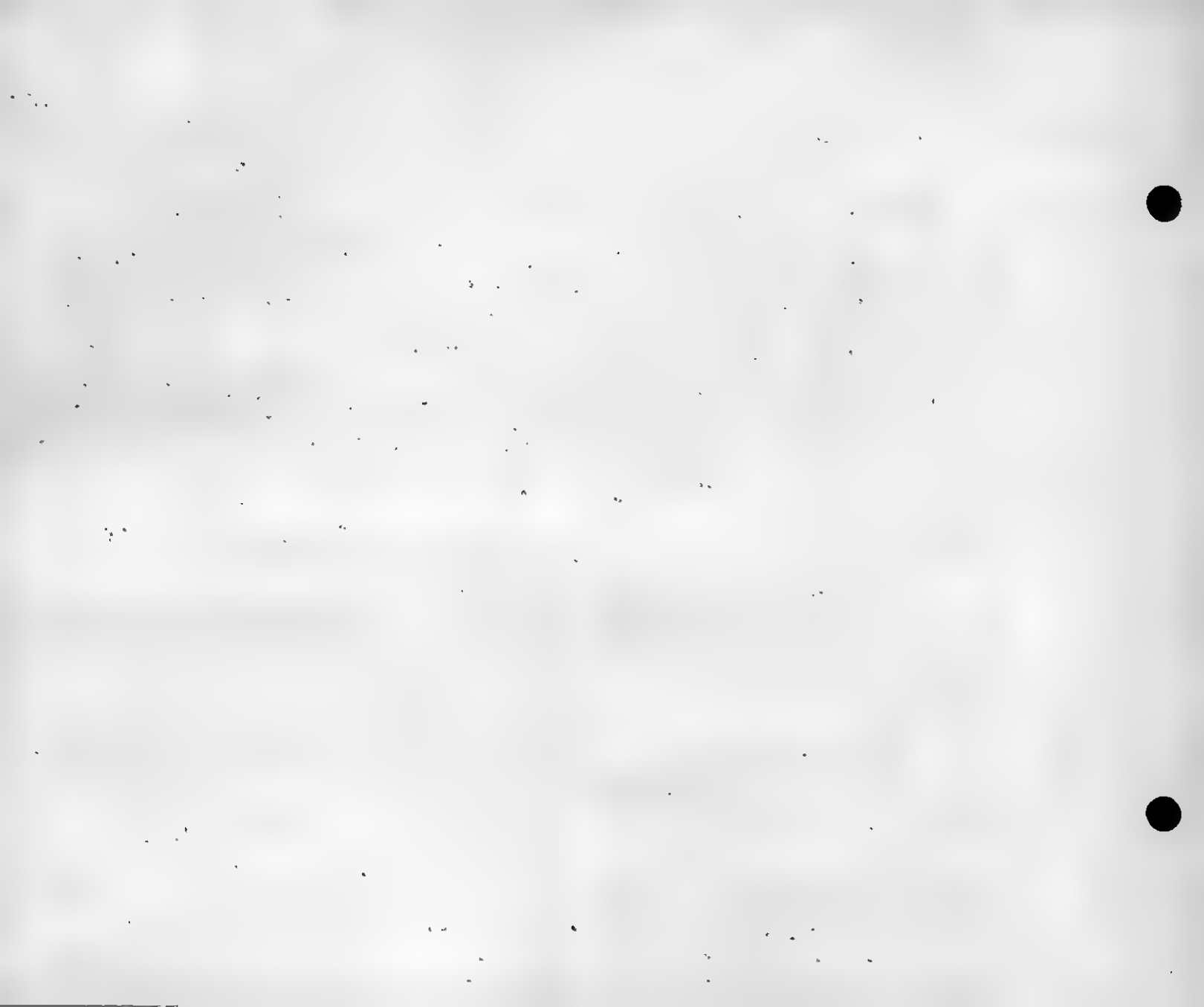


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <i>Nellye K. Spangler</i>			2a. DATE OF DEATH Month <i>Feb</i> Day <i>5</i> Year <i>68</i>			2b. HOUR <i>10:45</i> AM			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>8/15/1871</i>		6. AGE (In years last birthday) <i>96</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Assn. 12325 N. Hwy</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1746 Overlook Drive</i>	
14. FATHER'S NAME First <i>Charles</i> Middle <i>Louis</i> Last <i>Samaron</i>				15. MOTHER'S MAIDEN NAME First <i>Katherine</i> Middle <i>Allen</i> Last <i>Allen</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service) <i>xxx</i>				16b. SOCIAL SECURITY NO. <i>220-48-3983</i>		17. INFORMANT <i>George P. Spangler</i> Address <i>1746 Overlook Drive Hillandale</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sexualized Arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 weeks</i> <i>year</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Pneumonia for 3-4 days</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>60</i> , to <i>Feb 5</i> , 19 <i>68</i> , that (I) ( <i>we</i> ) lost the deceased alive on <i>Feb 5</i> , 19 <i>68</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>we</i> ) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert B. Irely</i> for MD				22c. DATE SIGNED <i>Feb 6 1968</i>		22d. PHYSICIAN'S NAME (Type) <i>Robert B. Irely</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Feb. 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>Charles C. Jones</i> Address <i>1234 N. Hwy</i>				25a. REC'D BY REGISTRAR <i>Charles Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			
25c. DATE <i>FEB 13 1968</i>				25d. ADDRESS <i>1234 N. Hwy</i>					

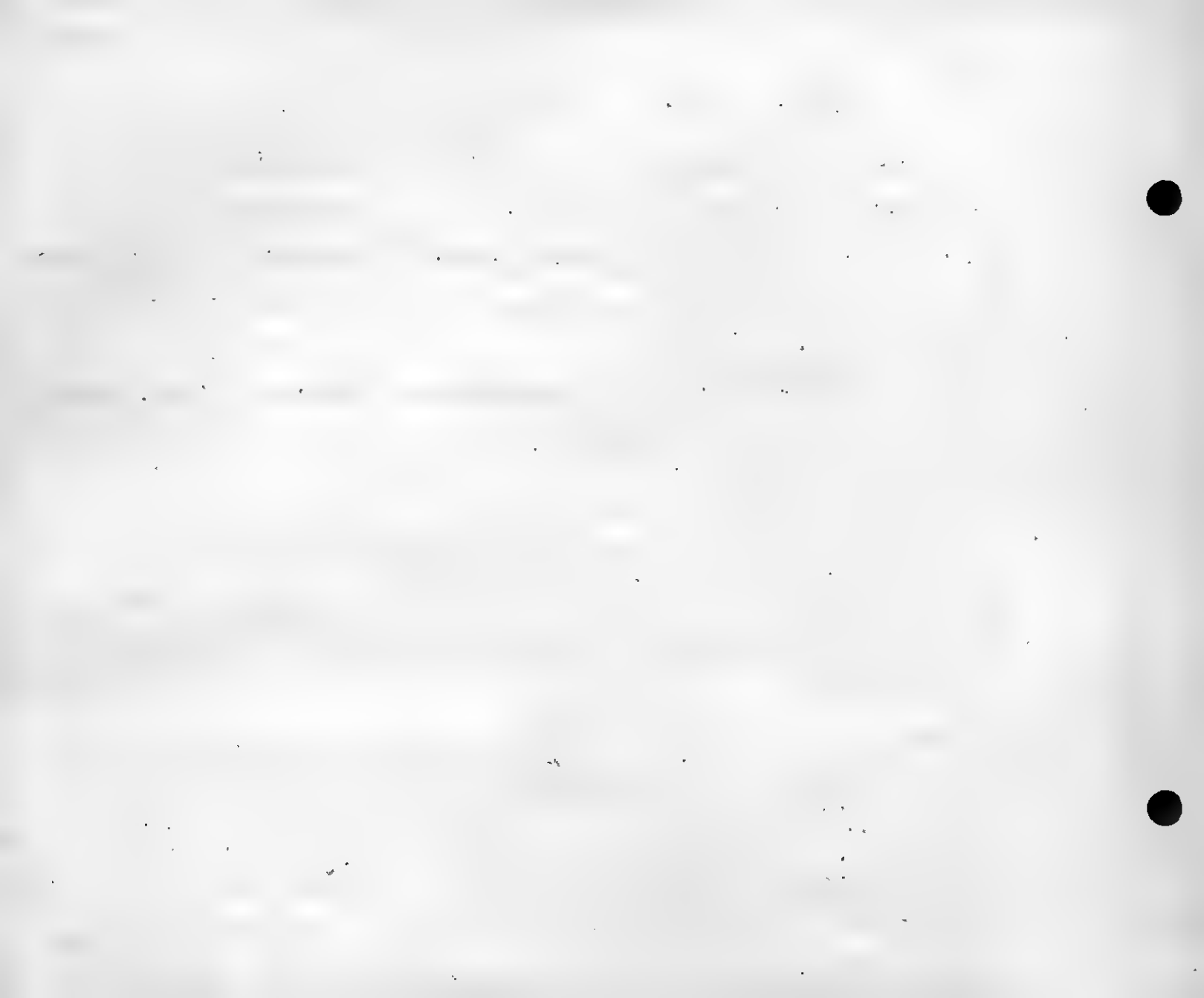


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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

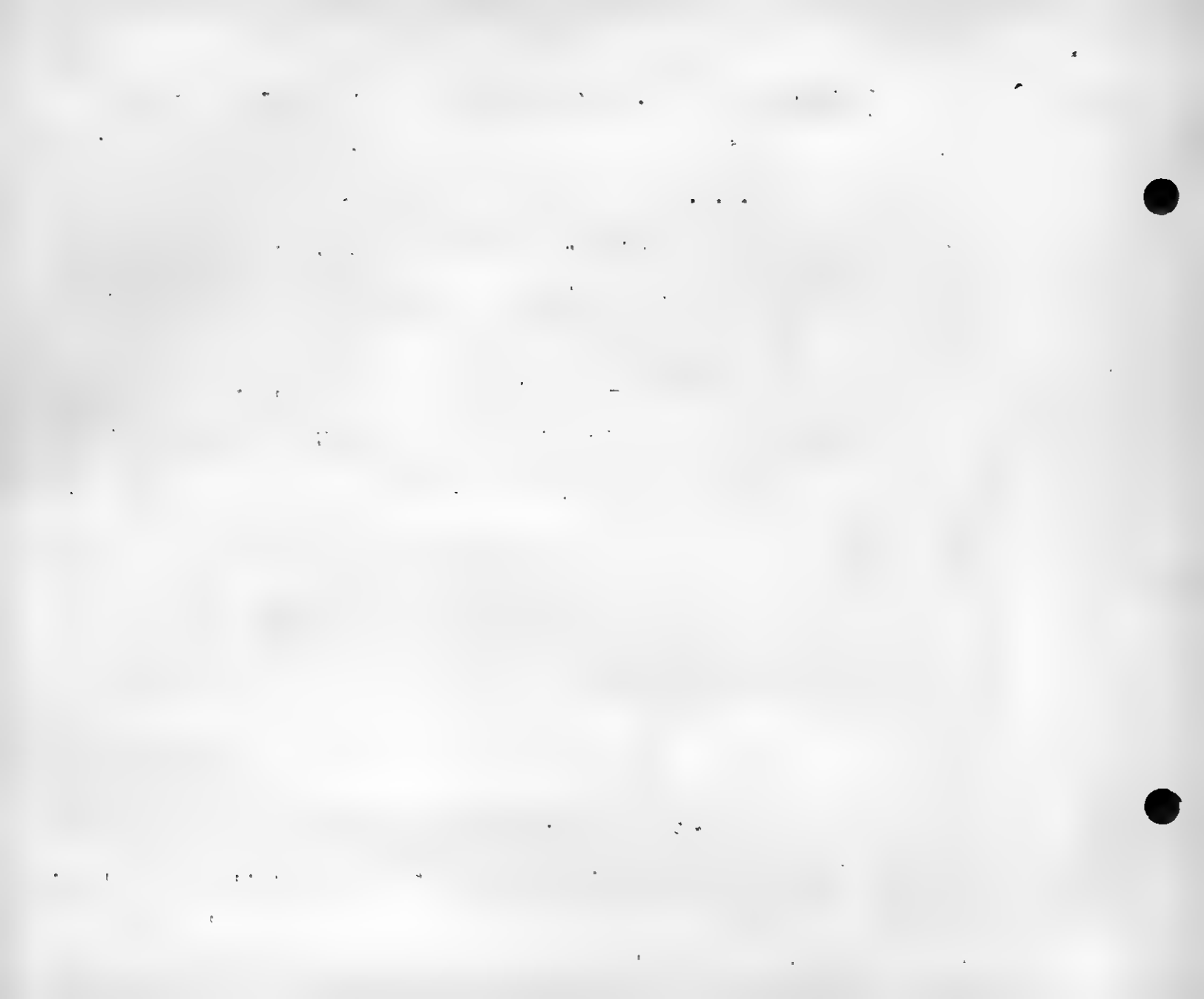
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
SARAH F STABLER						Month	Day	Year	5:55 P M	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White		Sept. 4. 1873			94 YRS		MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U S A				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Rockville			Potomac Valley Nursing			Housewife			at home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
D C			V		Wash	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6123 Broad Branch rd		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Roger Brooke Farquhar			Caroline Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			none		577.01.0697 B. Frances F. Bartram 11506 Cushman rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pneumonia</u>										
486X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4 Generalized atherosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION					
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1963, to 2-24, 1968, that (I) (we) lost saw the deceased alive on 2-24 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
D.C. Bucy									2-24-68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
D.C. Bucy					809 Veirs Mill Rd Mon7. Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		2.25.1968		Lee's Crematory		Washington D C				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lee Funeral Home 300.4th st N E Wash. D C					DATE		FEB 28 1968			



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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First VIRGINIA			Middle J.		Last STANG		2a. DATE OF DEATH February Month Day 24 Year 1968		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 5, 1918			6. AGE (In years last birthday) 49 YRS		IF UNDER 1 YEAR MONTHS 7 DAYS 19		IF UNDER 24 HRS HOURS M N		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				Md.			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Board of Education			12b. KIND OF BUSINESS OR INDUSTRY Cafeteria				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1704 Farragut Ave,				
14. FATHER'S NAME First Middle Last Ezekiel Testerman			15. MOTHER'S MAIDEN NAME First Middle Last Inez Bladen										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No			16b. SOCIAL SECURITY NO 213-16-9552		17. INFORMANT Address Joseph Martin Stang, Sr. husband-same #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL, BEGINNING ONSET AND DEATH 12 mos. sev. yes.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 318													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Marvin Wadler, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/24/68							
22d. PHYSICIAN'S NAME (Type) MARVIN WADLER		22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE 2/27/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville, Maryland					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR DATE FEB 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					





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VR-15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATE ON

1 DECEASED-NAME (Type or print) First Middle Last <i>Elhu H. Steele</i>				2a. DATE OF DEATH Month Day Year <i>Feb. 22 1968</i>		2b. HOUR <i>3:4</i> M			
3. SEX <i>male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>9/7/1893</i>		6. AGE (In years - last birthday) YRS. <i>74</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8715 Ewing Dr.</i>	
14. FATHER'S NAME First Middle Last <i>Daniel Steele</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Clemens</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>246-26-4463</i>		17. INFORMANT <i>JAMES M. STEELE - WIFE</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cholangitis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 days</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>neutrophilic leukocytosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/13</i> , 19 <i>68</i> , to <i>Feb. 22</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb. 21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jay R. Shapers MD</i>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Carver</i>		22e. ADDRESS <i>Beltsville, Maryland</i>		22f. DATE SIGNED <i>2/22/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/24/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Carver</i>		23d. LOCATION (City or Town) (County) (State) <i>Beltsville, Maryland</i>			
24. FUNERAL DIRECTOR <i>W. Ernest Jarvis Co.</i>				ADDRESS <i>1432 You Street, N.W.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

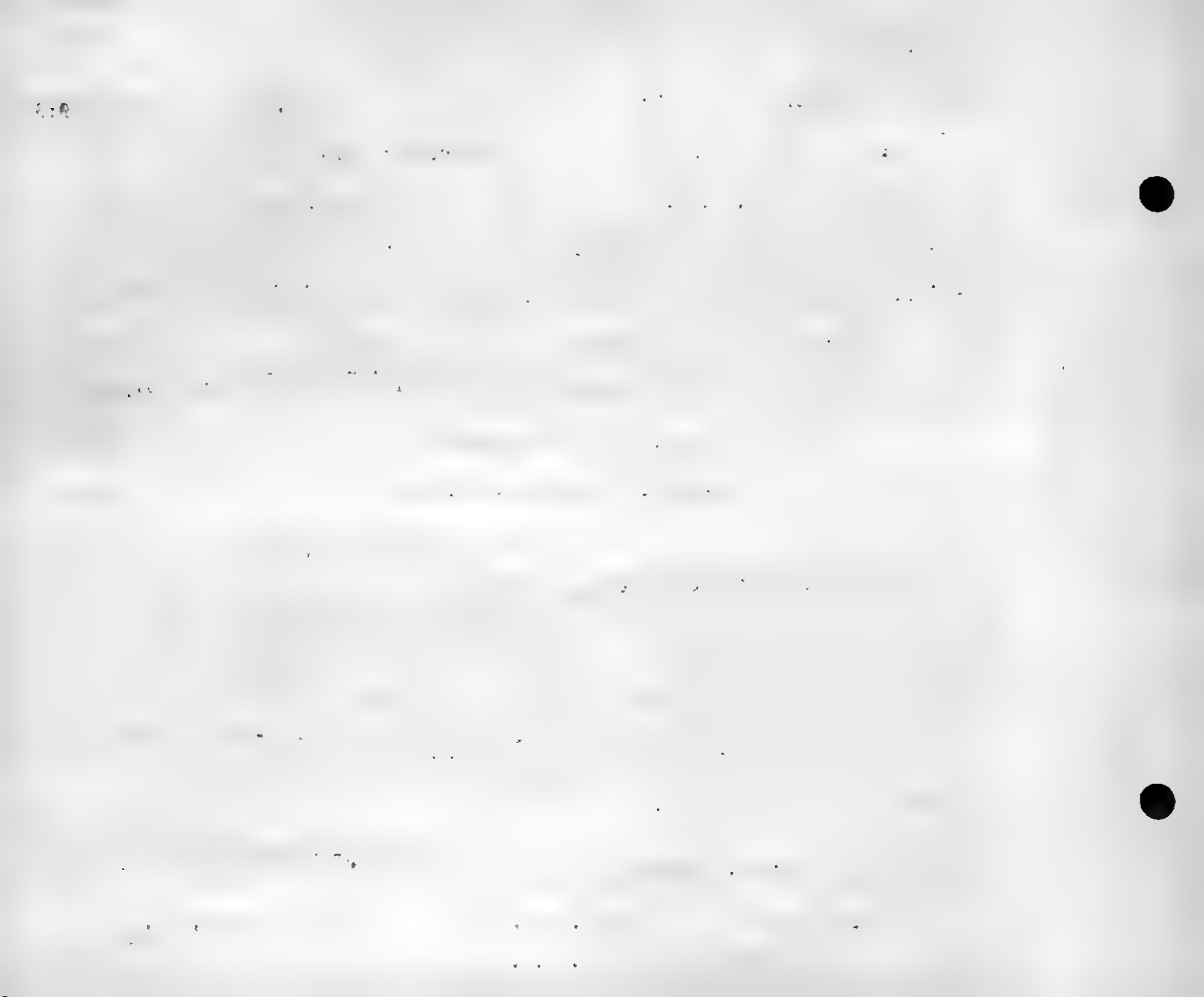


## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Esther</b>			First <b>Esther</b>			Middle <b>NMN</b>			Last <b>Stein</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1968</b>			2b HOUR <b>9:30</b> AM		
3 SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>18 December 1898</b>			6 AGE (In years last birthday) <b>69</b> YRS.			IF UNDER YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN			IF UNDER YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>								
10 CITY OR TOWN OF DEATH <b>Bethesda</b>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>The Clinical Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b KIND OF BUSINESS OR INDUSTRY <b>--</b>								
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>Washington, DC</b>			13b COUNTY <b>--</b>			13c CITY OR TOWN <b>Wash., DC</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>6632 Georgia Avenue, NW</b>					
14. FATHER'S NAME <b>Gershon</b>			First <b>Gershon</b>			Middle <b>Lustick</b>			15 MOTHER'S MAIDEN NAME <b>Sura</b>			First <b>Sura</b>			Middle <b>Needle</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			(If yes give war or dates of service) <b>--</b>			16b. SOCIAL SECURITY NO <b>578-62-6614</b>			17 INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>2051</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>2071</b> (b) <b>Chronic Myelogenous Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>1 year</b>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Generalized arteriosclerosis (years)</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. if YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>28 August</b> , 19 <b>67</b> , to <b>25 Feb</b> , 19 <b>68</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>25 February</b> 19 <b>68</b> , and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(X)</del> (we) (did) <del>(did not)</del> view the body after death.																	
22b. SIGNATURE <b>CM Haskell, MD</b>			DEGREE <b>MD</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>25 February 1968</b>								
22d. PHYSICIAN'S NAME (Type) <b>Charles M. Haskell, MD</b>			22e ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>														
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>			23b DATE <b>2-27-68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Va.</b>								
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>			ADDRESS <b>4217 9th St. N.W.</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 27 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

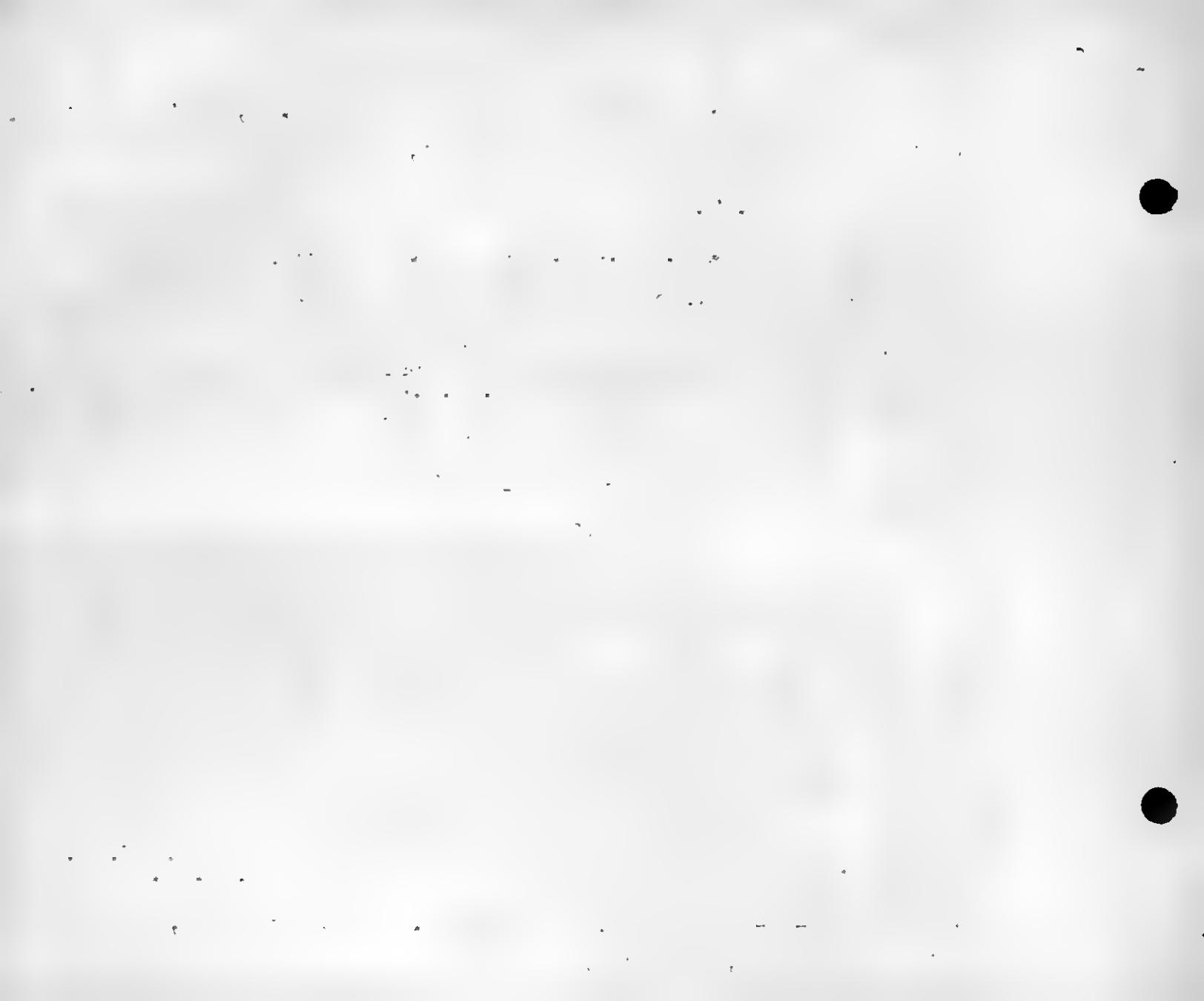


## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>SUE P. STEVENS</b>			2a. DATE OF DEATH Month <b>Feb</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>6:30</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 15, 1871</b>		6. AGE (In years last birthday) <b>96</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Beth. Sil. Spr. Nussing H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
13e. STREET AND NUMBER <b>5114 Hampden Lane</b>		14. FATHER'S NAME First <b>Samuel</b> Middle <b>Phillips</b> Last		15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Stafford</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Daughter</b> Address <b>Mrs. C.H. Kenton</b> Same as Item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Failure of the circulation</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senescent arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>20 years</b> <b>20 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4129</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-4</b> , 19 <b>67</b> , to <b>2-7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1-31</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <b>12/8 MISH</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-8-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>K. HAMMOND MISH</b>				22e. ADDRESS <b>3800 Jenifer St., N. W. Washington, D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Sudlersville, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

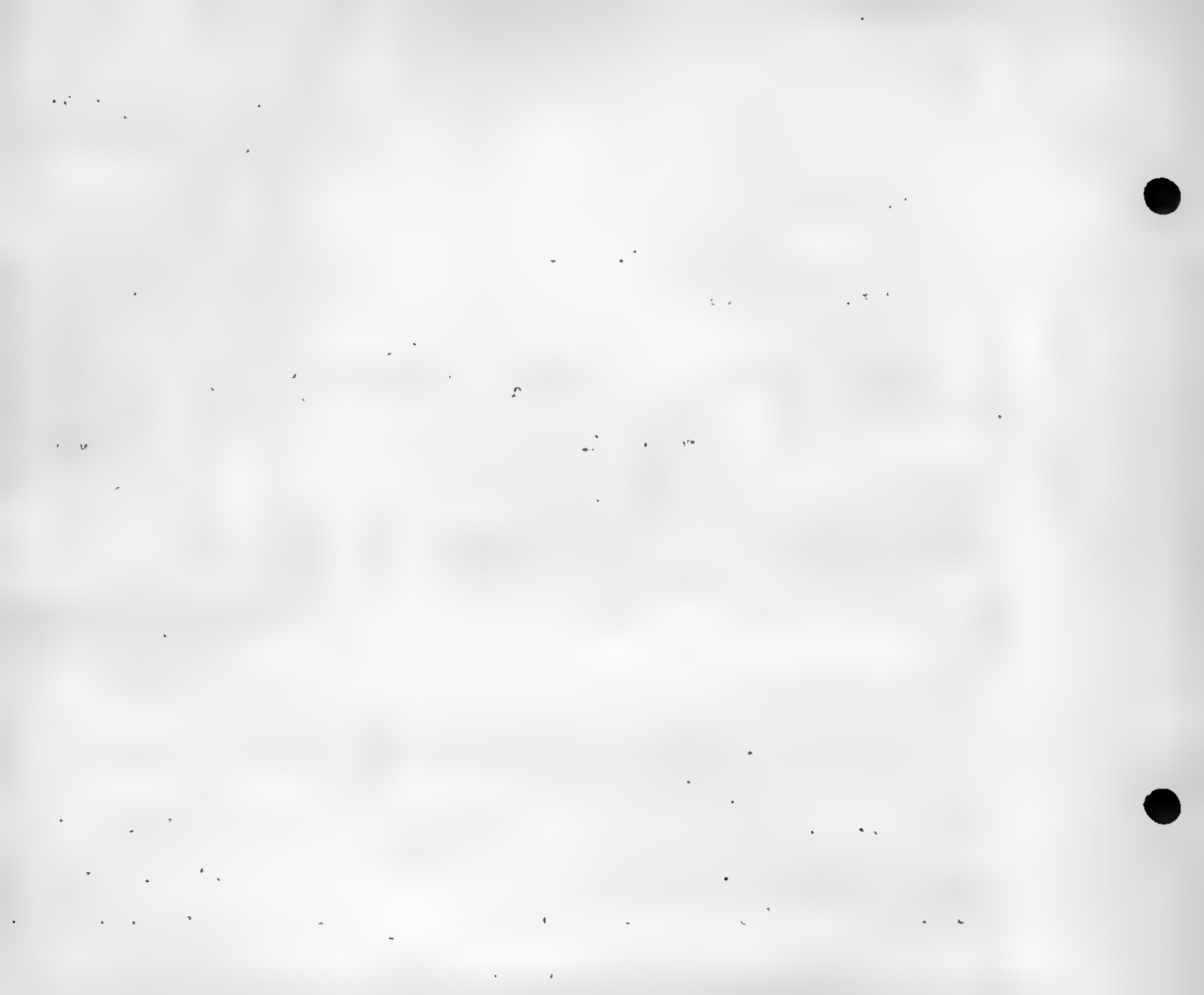
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Sharon			Ann			February 11, 1968			7:29 AM
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Female		White		2 February 1950		18 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			The Clinical Center, NIH			Student			---
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Prince Georges		Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3700 63rd Avenue
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Francis C. Stockstill			Mary Ellen Osborne						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT				
No			None		The Medical Record Address 20014 The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest									Minutes
DUE TO, OR AS A CONSEQUENCE OF									
(b) Craniopharyngioma									Years
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
21a. DATE OF OPERATION									
21b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (this hospital) attended the deceased from February 10, 1968, to February 11, 1968, that (it) (we) last saw the deceased alive on February 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (it) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Nicholas E. Grivas MD DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. DATE SIGNED 12 February 1968									
22d. PHYSICIAN'S NAME (Type) Nicholas E. Grivas, MD									
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/14/68		Ft. Lincoln		Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
V Francis Gasch's Sons Hyattsville, Md.					DATE FEB 15 1968		Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
2026  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <u>Sarah Catherine Stolz</u>			2a. DATE OF DEATH <u>Feb 13 1968</u>			2b. HOUR <u>1:15</u> M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Oct 10 1889</u>		6. AGE (In years last birthday) <u>78</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.					
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY OR TOWN? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>13213 Superior St.</u>			
14. FATHER'S NAME First <u>Henry</u> Middle <u>Thunder</u> Last <u>Thunder</u>			15. MOTHER'S MAIDEN NAME First <u>Hattie</u> Middle <u>Castle</u> Last <u>Castle</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes, no, or unknown</u>			16b. SOCIAL SECURITY NO.			17. INFORMANT <u>Frances J. Scobin</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>H129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus, brittle</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>68</u> , to <u>Feb 13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George Skenton, MD</u>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/13/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>George S. Kenton</u>				22e. ADDRESS <u>Rockville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>2-17-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		23d. LOCATION (City or Town) (County) (State) <u>Petersville, Frederick Md</u>					
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>				ADDRESS <u>Leithersburg, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>FEB 19 1968</u>							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1-7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
ALFRED		D.		STOTLER				2a. DATE KNOWN OF DEATH		2b. HOUR	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7c. DATE PRONOUNCED DEAD		7d. HOUR	
MALE		CAUC		9/8/21		46 YRS.		2-26		9:45 A.M.	
7a. BIRTHPLACE (State, or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH					
W. Va.		U.S.		WIDOWED		MONTGOMERY					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Clney		Montgomery Gen. Hosp. Breckinridge		Building							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER					
PENNSA		SHIPPENSBURG		61 W. KING ST.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Isaac D. Stotler		Vertie Bohrer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
Yes		WW II		Hosp. Records							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Broncho pneumonia with											
DUE TO, OR AS A CONSEQUENCE OF (b) right empyema.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Pulmonary Emphysema											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
CAUSE OF DEATH				19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
Belden R. Reap				M.D.				3/26/1968			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER							
BELDEN R. REAP M.D.				ADDRESS (City, town, or county)							
23a. BURIAL, CREMATION, or other disposal (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				3/1/68				Greenway			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Sydney H. Reap				MAR 4 1968							
1331 Rockville Pike, Rockville, Md.											



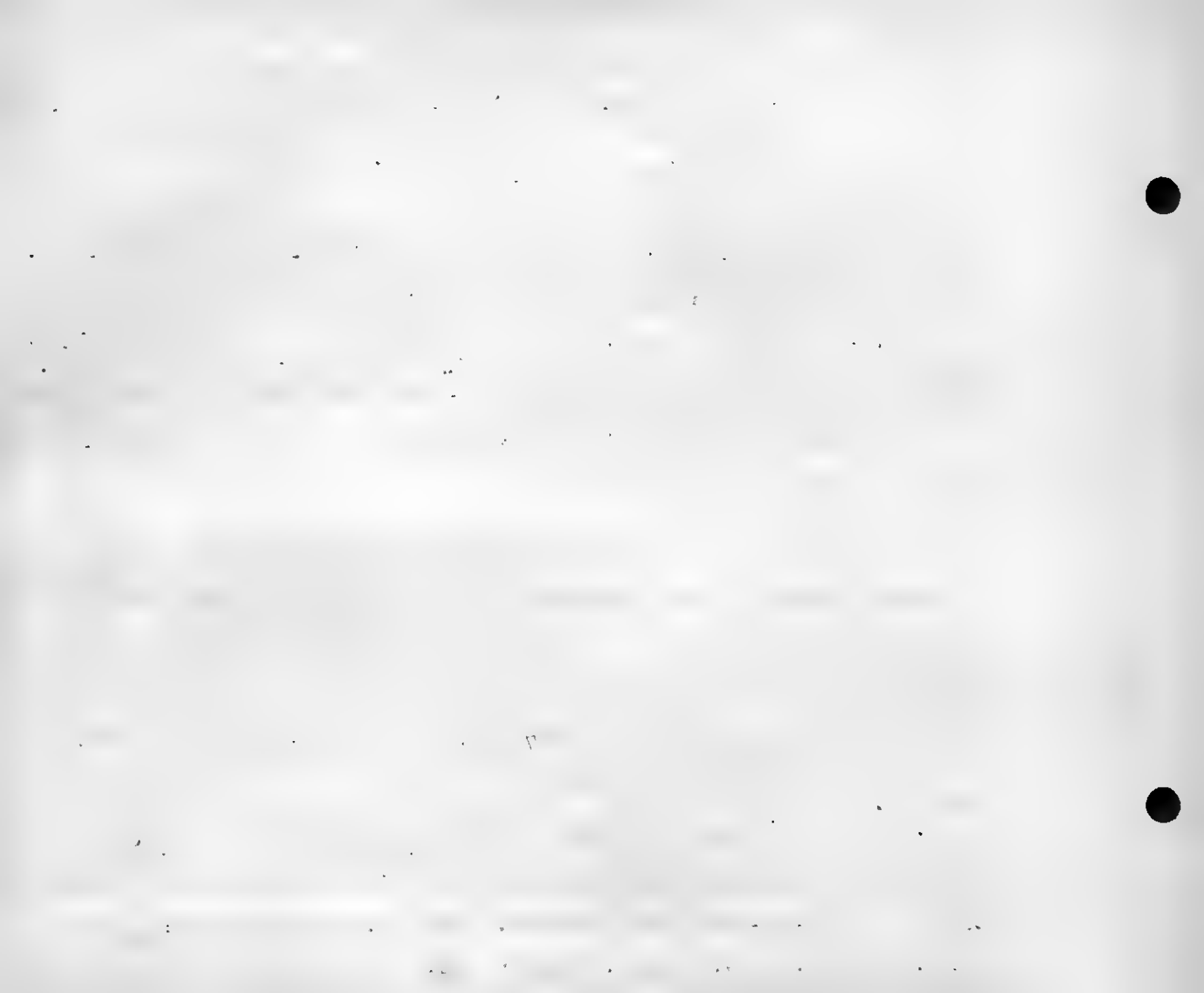
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15/14  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) First Middle Last <b>Madeline Virginia Stouffer</b>			2a. DATE OF DEATH Month Day Year <b>February 9, 1968</b>		2b. HOUR PM <b>5:25</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>29 May 1923</b>		6. AGE (In years last birthday) <b>44</b> YRS.	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bench Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Leather Co.</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Funkstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>8 East Chestnut Street</b>	
14. FATHER'S NAME First Middle Last <b>John Ruth</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Nora Holliday</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/> (If yes give year or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-14-8315</b>		17. INFORMANT <b>The Medical Records, Address Bethesda, Md.</b> <b>The Clinical Center, National Inst. of Health.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malignant Melanomatosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>110</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (A) (this hospital) attended the deceased from <b>7 February, 1968</b> , to <b>9 February, 1968</b> , that (X) (we) last saw the deceased alive on <b>9 February, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Harold R. Gertner, Jr.</i> MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10 February 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Harold R. Gertner, Jr., M.D.</b>		22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-13-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park, Inc.</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 14</b>		25b. REGISTRAR'S SIGNATURE	



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*Signature of Physician*  
*Signature of Funeral Director*  
*Signature of Registrar*

**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Percy A. well Taylor</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>12:55</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2/15/68</b>		6. AGE (In years last birthday) <b>67</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Albany Co Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County</b>	
10. CITY OR TOWN OF DEATH <b>// Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Postal Clerk Gov't</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>6414 20th Ave W.</b>		13f. CITY OR TOWN <b>Hyattsville</b>					
14. FATHER'S NAME <b>W. Riley Taylor</b>			15. MOTHER'S MAIDEN NAME <b>Mattie Edwards</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (give year or dates of service) <b>Yes WW I</b>		16b. SOCIAL SECURITY NO <b>220 44 1964</b>		17. INFORMANT <b>Mrs. P A Taylor</b>			
				Address <b>6414 20th Ave W Hyattsville Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410.0 Acute - Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension with Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 sudden</b> <b>2 yrs.</b> <b>2 yrs.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <b>1/5</b> , 19 <b>68</b> , to <b>2/5</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>2/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Francis X. Richardson M.D.</i>				22c. DATE SIGNED <b>2/5/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Francis X. Richardson M.D.</b>				22e. ADDRESS <b>11412 Veirs Mill Road, Sil. Sprng. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 8, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>John S. Thompson &amp; Son, Inc.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





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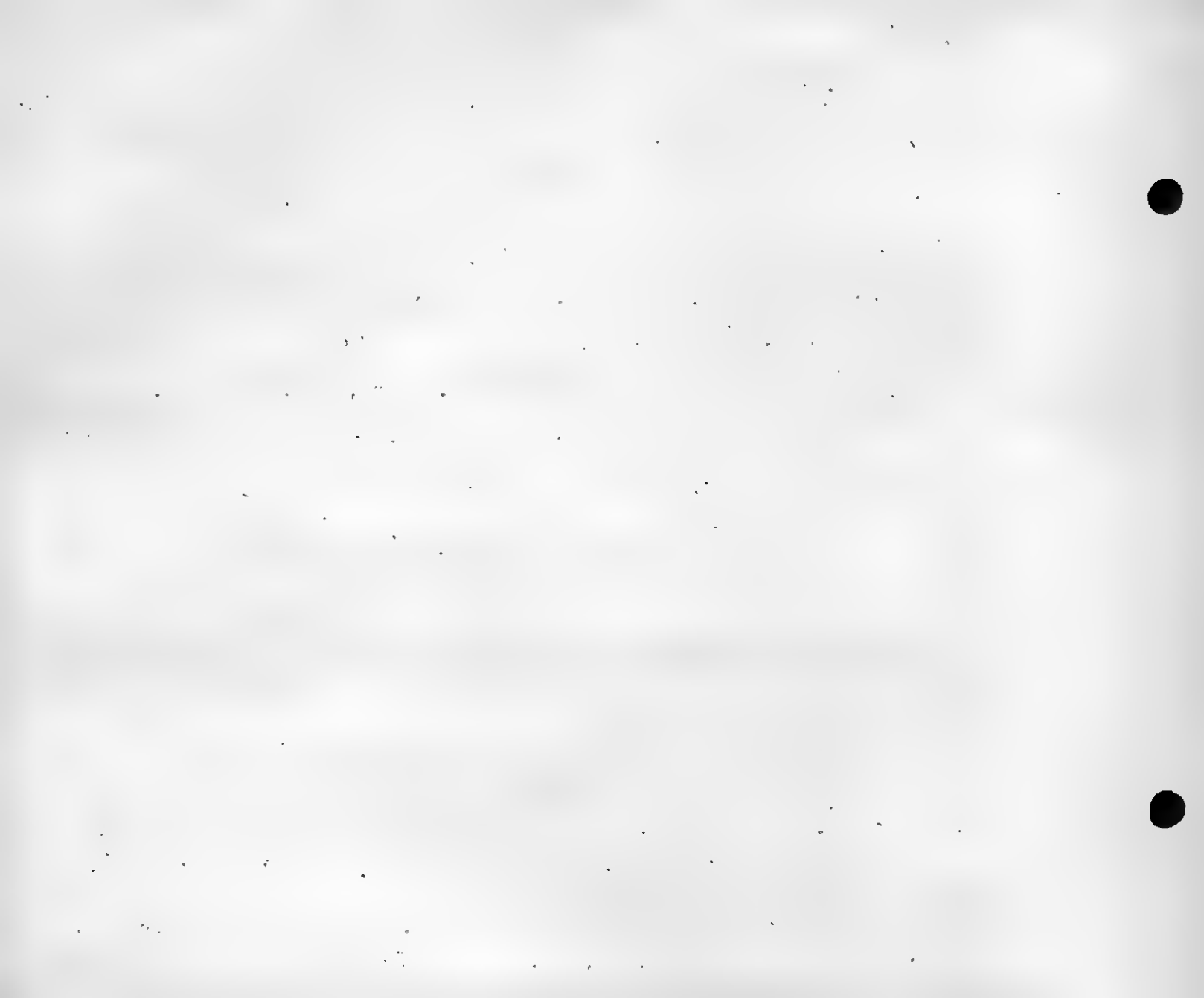
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b HOUR
William			HENRY		THEOPHILE		FEB 17 1968			11:15 M.		
3. SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
Male		W		July 29, 1887			80 YRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md.
Illinois			U. S. A.						Montgomery			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
Bethesda			Suburban			Managerial			INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Mont			Potomac			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12801 View Rd	
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First
William			Theophile						Adele Thompson			Daughter
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17. INFORMANT			Address			
No			578-03-7174			Adele Thompson			Daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Diffuse B.I. Bleeding											12 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Stress & Uremia (acute renal failure)											3 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic acidosis & coma											3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from Aug, 1964, to 2-17, 1968, that (I) (we) last saw the deceased alive on 2-17, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b SIGNATURE						22c DATE SIGNED						
D. F. Sengstack M.D.						2-17-68						
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
GEO. F. SENGSTACK						9421 COL BLVD. SILVER SPRING, MD.						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
CREMATION			2/19/68		CEDAR HILL CREMATORY			SUITLAND, MD.				
24 FUNERAL DIRECTOR						25a. RECEIVED BY REGISTERAR			25b. REGISTERAR'S SIGNATURE			
JOS. GAULER'S SONS, 5130 WIS. AVE. WASH., D.C.						FEB 21 1968			[Signature]			



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <sup>First</sup> Michael <sup>Middle</sup> Anthony <sup>Last</sup> Thomas						2a. DATE OF DEATH Month Day Year Feb. 17 68			2b. HOUR 5:17 AM		
3 SEX male		4. RACE white		5. DATE OF BIRTH 2-15-68		6. AGE (In years lost birthday) YRS. MONTHS DAYS 2 2		IF UNDER 1 YEAR MONTHS DAYS 2		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RFD # 3		
14. FATHER'S NAME <sup>First</sup> Aaron <sup>Middle</sup> William <sup>Last</sup> Thomas				15. MOTHER'S MAIDEN NAME <sup>First</sup> Sandra <sup>Middle</sup> Hawthorn <sup>Last</sup>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. -		17 INFORMANT Address Vernon Georg, Mt. Airy, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congenital cardiac disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis + Hypoplasia left Ventricle</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 52 hrs 24 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1-4											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-15</u> , 19 <u>68</u> , to <u>2-17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard M. Auld</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-17-68			
22d. PHYSICIAN'S NAME (Type) RICHARD M. AULD						22e. ADDRESS 809 Viers Mill Rd. Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Poplar Springs Meth.		23d. LOCATION (City or Town) Poplar Springs, Md.		(County)		(State)	
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.						25a. REC'D BY REGISTRAR DATE FEB 20 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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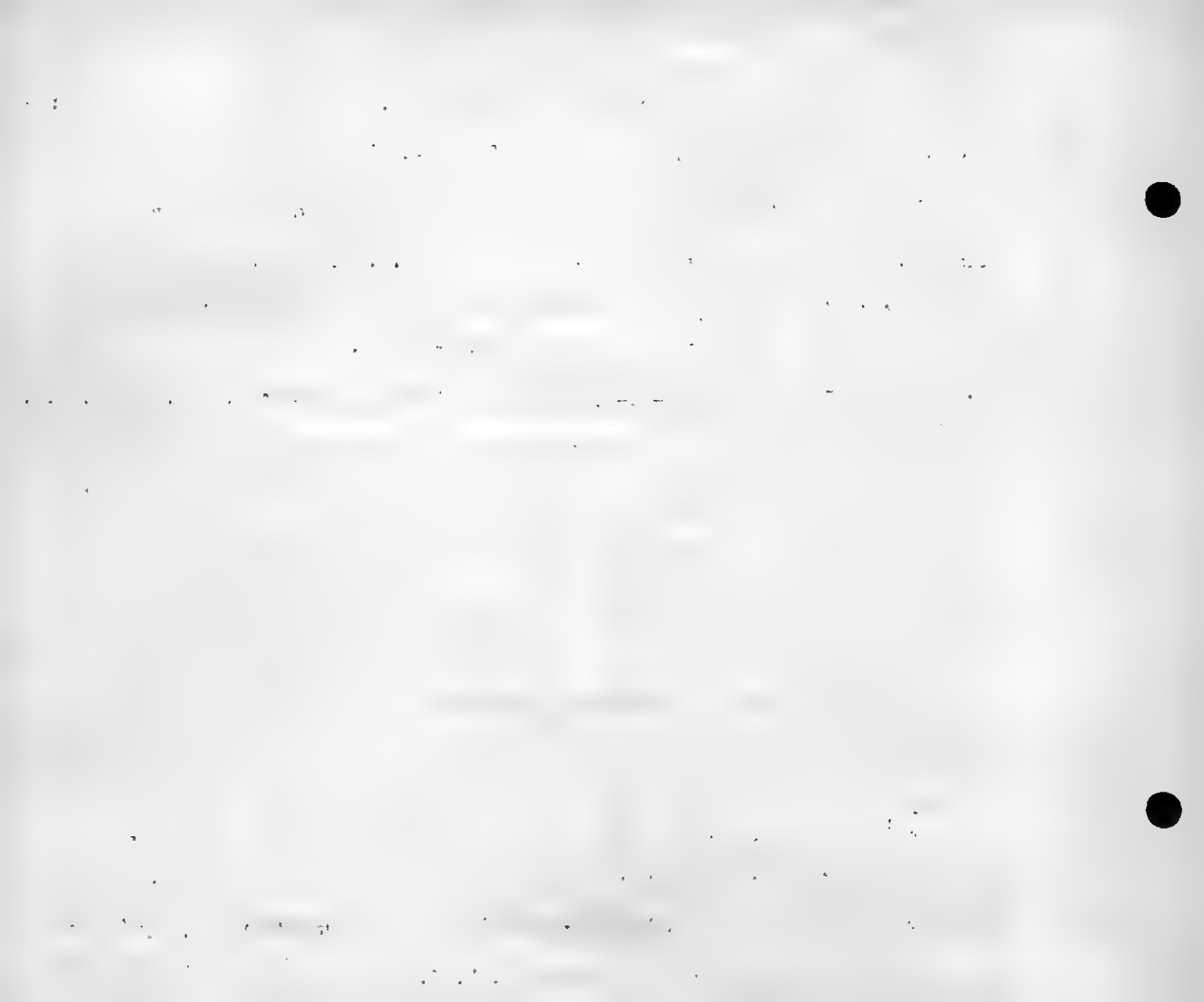
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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Thomas Edward THRASHER Jr.</b>		2a DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1968</b>		2b HOUR <b>1005P</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasion</b>		5 DATE OF BIRTH <b>27 August 1887</b>	
6 AGE (In years lost birthday) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery County</b>		Md.			
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>	
12b KIND OF BUSINESS OR INDUSTRY <b>Military</b>					
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d STREET AND NUMBER <b>2100 Mass. Avenue</b>					
14. FATHER'S NAME First Middle Last <b>Thomas Edward THRASHER</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Eliza A. Deats</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>070-14-7945</b>		17. INFORMANT Address <b>Mary THRASHER, 2100 MASS. AVE., WASH. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG DISSEMINATED</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. _____ 19 _____		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>26 DEC</b> , 19 <b>67</b> , to <b>9 FEB</b> , 19 <b>68</b> , that <b>(H)</b> (we) lost saw the deceased alive on <b>9 FEB</b> , 19 <b>68</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(H)</b> (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>R. J. Kinney, M.D.</b>		DEGREE <b>LCDR R. J. KINNEY MD.</b>		22c DATE SIGNED <b>10 FEB 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>LCDR R. J. KINNEY MD.</b>		22e ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>			
23a BURIAL, CREMATION, OR OTHER DISPOSITION <b>CREMATION</b>		23b DATE <b>2/12/1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
23d LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>					
24 FUNERAL DIRECTOR ADDRESS <b>JOSEPH GAWLERS 5130 WISCONSIN AVE. WASH. D.</b>		25a REC'D BY REGISTRAR <b>DATE FEB 15 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



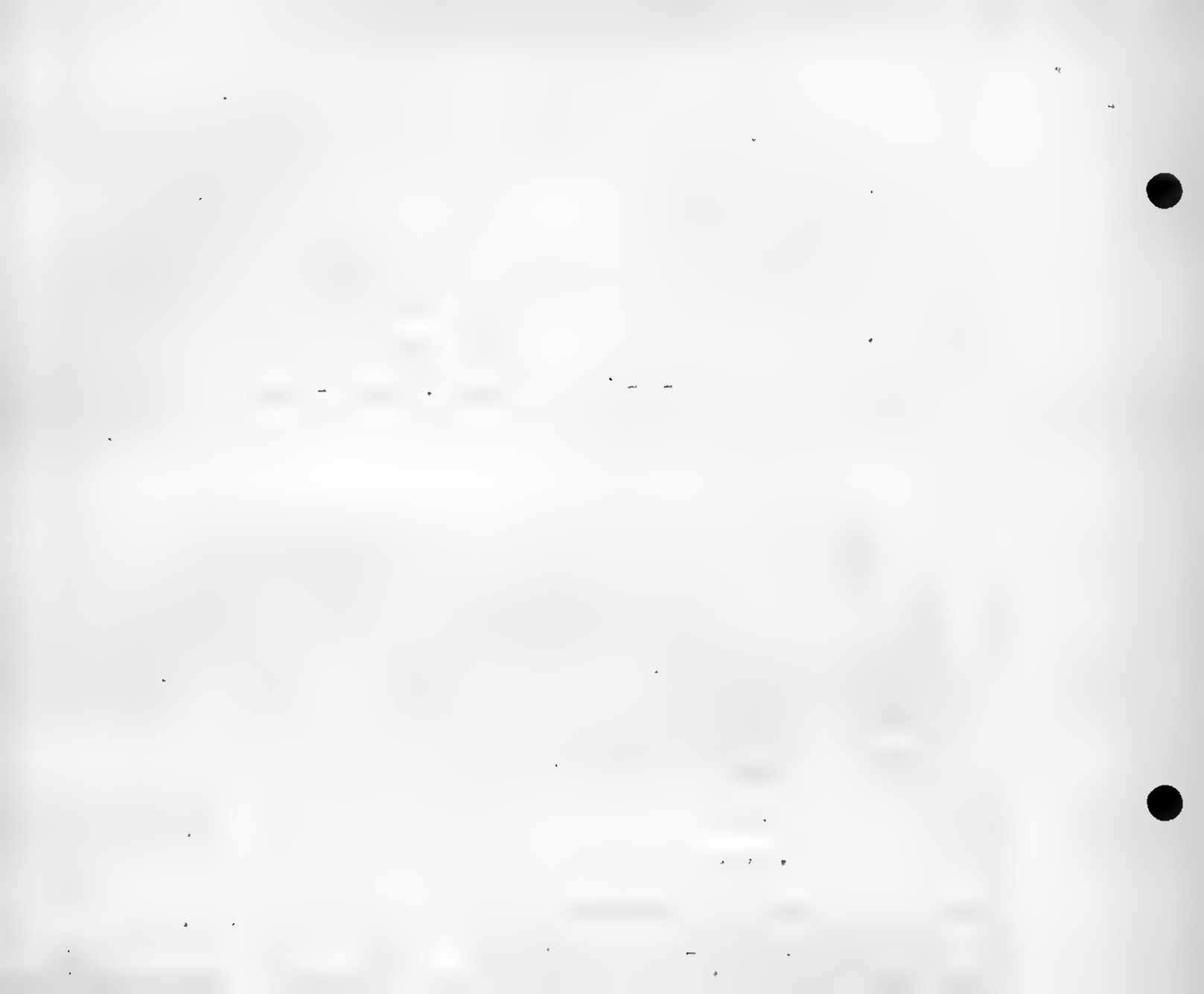
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

BR

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
David Allen Trumbo								Feb 2 1968		8:40 AM
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD
M.	W.	8/18/46		22 YRS						May 5 1968 11 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				Md
Maryland		US				Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Whites Ferry		Potomac River				Student		School		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.		Montgomery		Rockville				107 Virginia Ave		
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
Everett A. Trumbo				Mary Coate						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT				ADDRESS		
No		220-48-6444		Everett A. Trumbo -Item # 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning										5 min?
30.0 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
150										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
				8:30 am Feb 2, 1968		Turned over in - Kayak - Canal -				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County		State
		Potomac River		Whites Ferry		Potomac River		Montgomery		Md
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
EXAMINER'S NAME (Type)		John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		May 5, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		5/7/68		Parklawn		Rockville, Md.				
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Tyson Wheeler Funeral Home-1331 Rockville Pike				Rockville, Md.		DATE MAY 7 1968		Charles Judge		



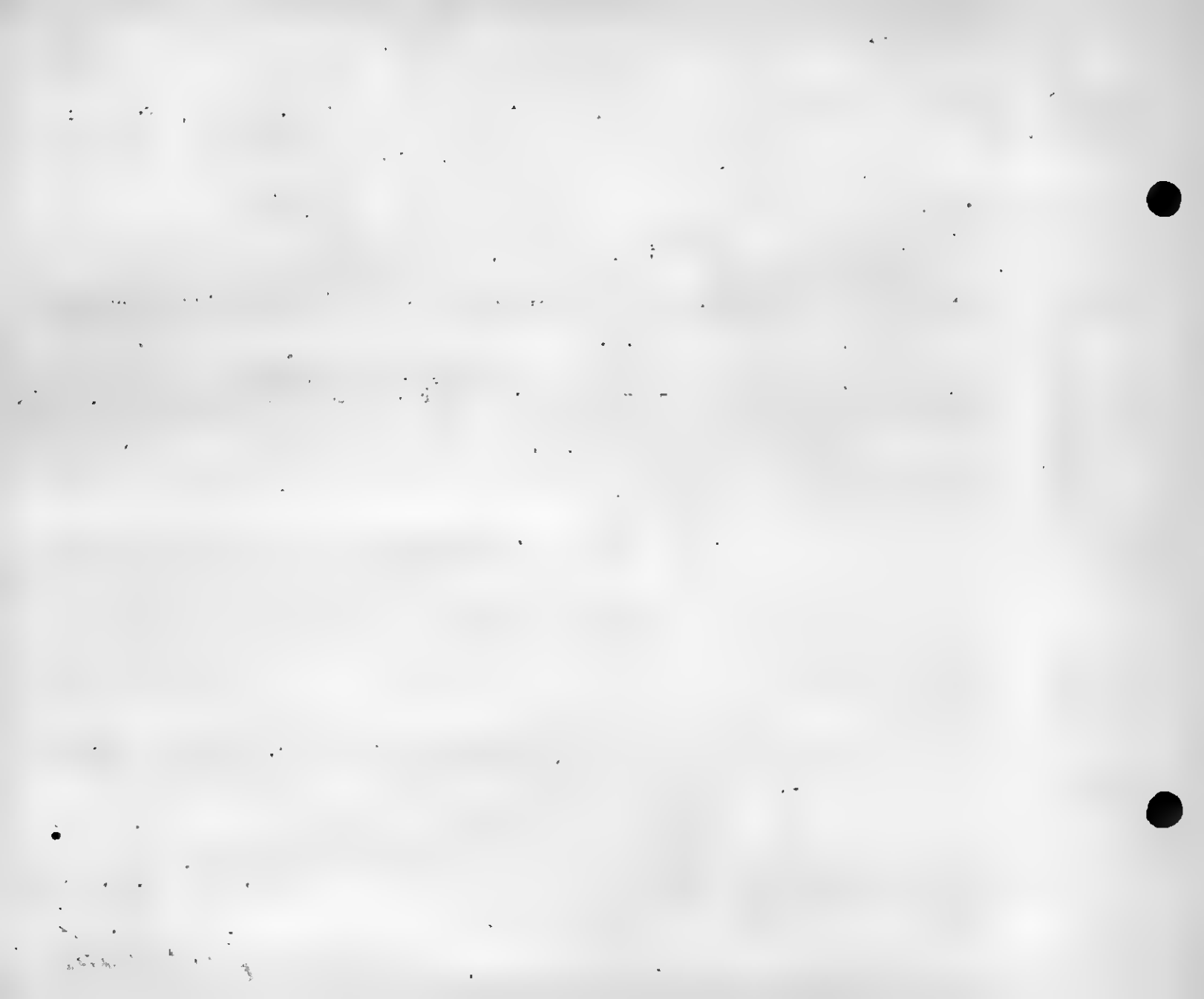


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

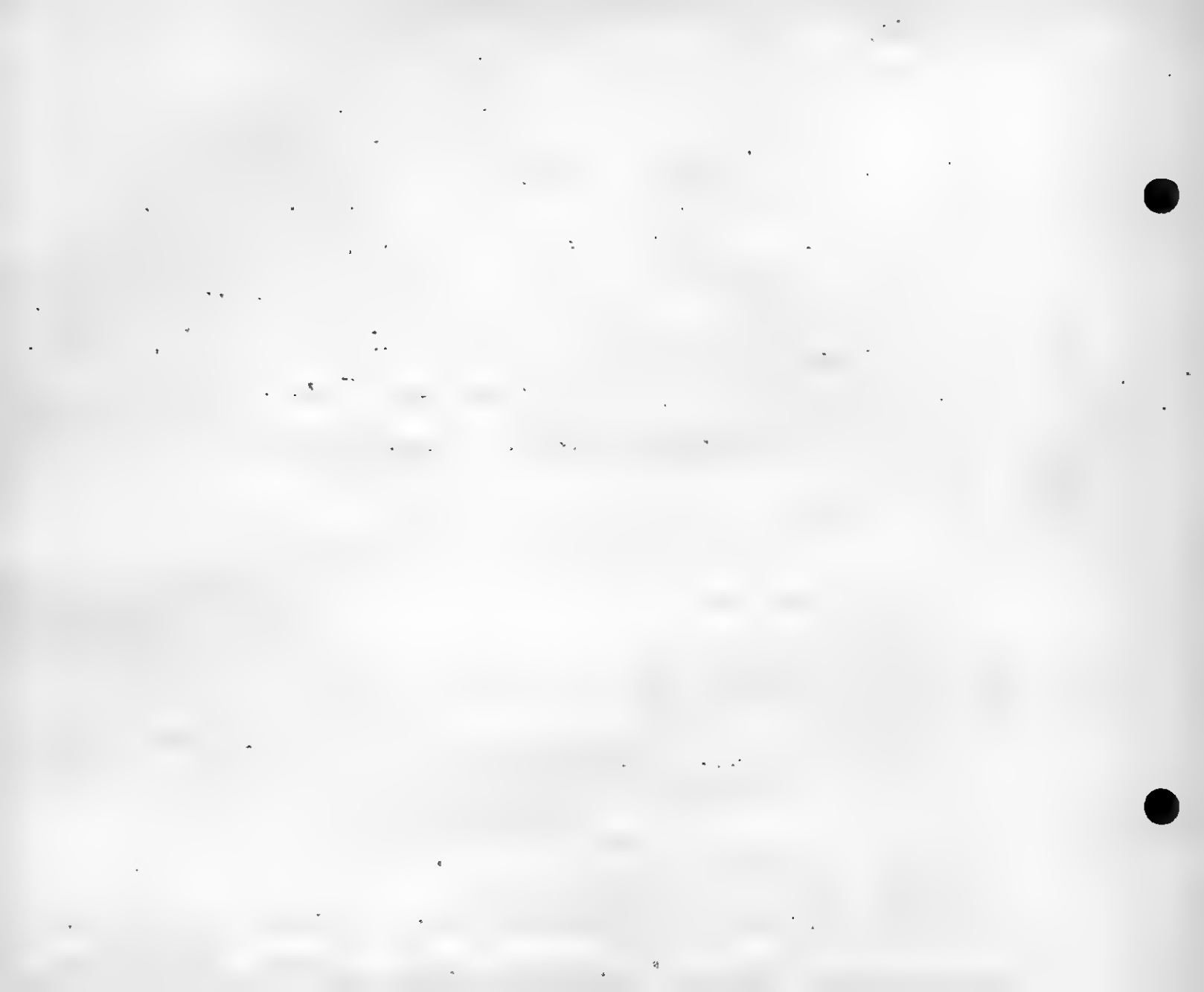
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <b>Carlton Jackson Turner</b>						2a. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>12:10</b> AM			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>20 July 1918</b>			6. AGE (In years last birthday) <b>49</b> YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md						
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY (IM-TS) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>114 West Wilson Boulevard</b>			
14. FATHER'S NAME First <b>Wilmer</b> Middle <b>Turner</b> Last				15. MOTHER'S MAIDEN NAME First <b>Celia</b> Middle <b>Daily</b> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>Yes 1943-45</b>			16b. SOCIAL SECURITY NO <b>198-01-7047</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland 20014</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Mycosis fungoides</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>years</b> <b>3 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>October 4, 1967</b> , to <b>Feb. 12, 1968</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>February 12, 1968</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Arthur R. Ugel</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12 February 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Arthur R. Ugel, M.D.</b>						22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-14-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Clear Spring, Md.</b>						
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



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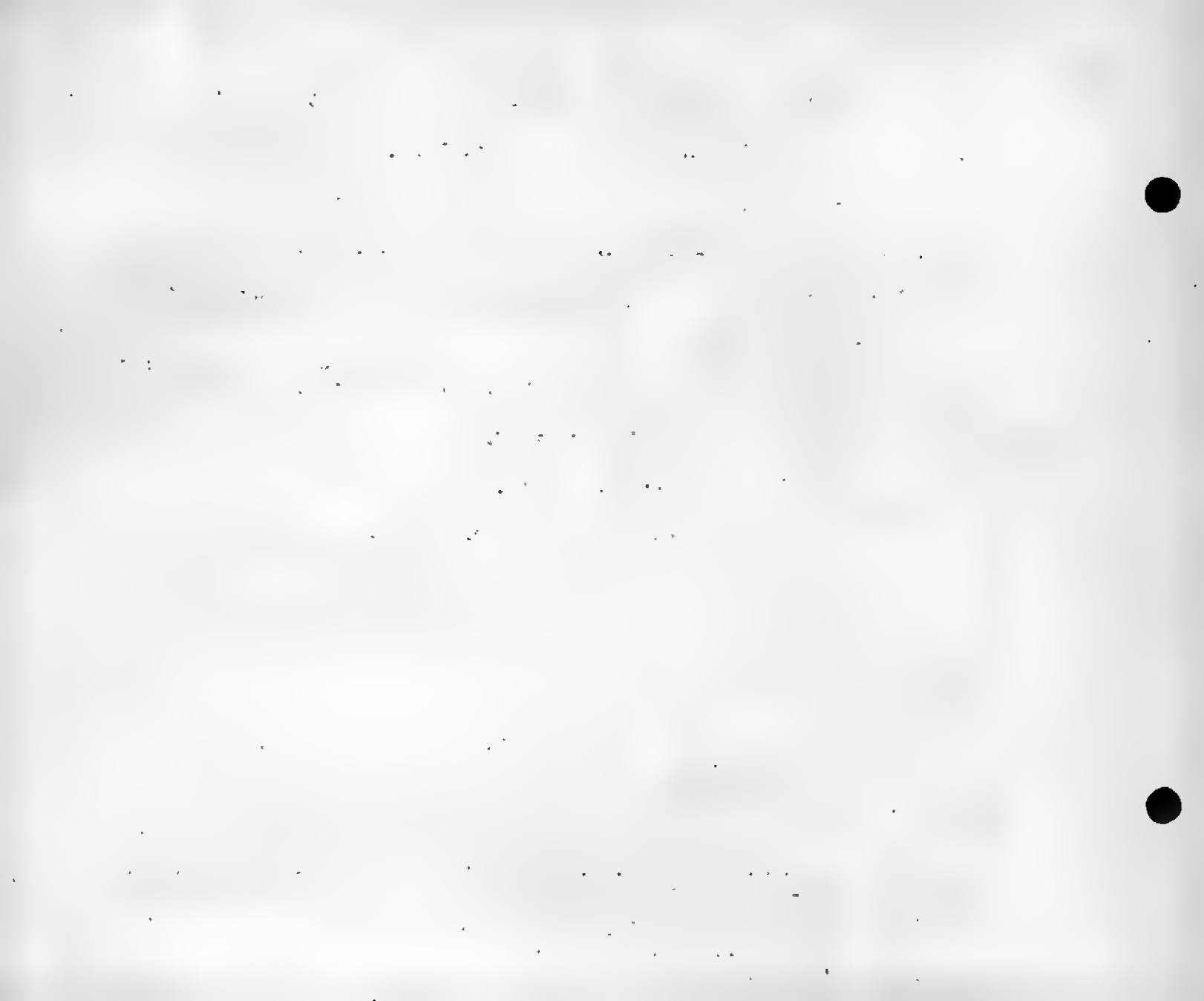
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last <b>ALBERT GEORGE TUTEM</b>						2a. DATE OF DEATH Month Day Year <b>FEB 14 1968</b>			2b. HOUR <b>5:00 A.M.</b>		
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7/21/03</b>		6 AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md					
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>BANKER</b>			12b KIND OF BUSINESS OR INDUSTRY <b>RECORDING</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm'ssion) STATE <b>NEW JERSEY</b>			13b COUNTY <b>CHERRY HILL</b>		13c CITY OR TOWN <b>CHERRY HILL</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>42 WAGON LANE</b>		
14. FATHER'S NAME First Middle Last <b>GEORGE TUTEM</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>IDA BUTTERWORTH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>NO</b>				16b. SOCIAL SECURITY NO.		17 INFORMANT Address <b>MARGARET TUTEM - WIFE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting aneurysm, ruptured, thoracic and abdominal aorta</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>751X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 1968, to <b>2/14</b> , 1968, that (I) (we) last saw the deceased alive on <b>2/14</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. O. Dean MD</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>2/14/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>J. O. DEAN</b>				22e. ADDRESS <b>11104 Luxmanor Rd Rockville</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Cherry Hill, N. J.</b>			
24. FUNERAL DIRECTOR <b>Lee Funeral Home,</b>				ADDRESS <b>Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>FEB 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M		
George Benjamin UEBELE						February 24 1968		730P		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		Feb. 13, 1892		76 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Madison, Indiana		USA				Montgomery Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda,		Naval Hospital		U.S. Navy						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia			V		Annandale		YES <input type="checkbox"/> NO <input type="checkbox"/>		7410 Austin Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Joseph Uebele										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
yes					Annandale Virginia Mrs. Estella Uebele, 7410 Austin Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 3</u> , 19 <u>68</u> , to <u>Feb. 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>R. J. Kinney, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>Feb. 26, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>R. J. KINNEY, M. D.</u>					22e. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2/28/68		Arlington National Cemetery		Arlington, Virginia				
24. FUNERAL DIRECTOR <u>Covington &amp; Martin, 6161 Leesburg Pike, Falls Church, Virginia</u>					25a. REC'D BY REGISTRAR <u>FEB 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A M		
Roy Edward Verderber, Jr.						February 11, 1968		1:25 A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		8 October 1959		8 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Ohio		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center, NIH			Student				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia			---		Falls Church		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2142 Hilltop Place	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Roy Edward Verderber			Lois A. Bitter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			None		The Clinical Center, Bethesda, Maryland 20014, Medical Records, Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									12 days	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) <u>Hydrocephalus</u>									2 years	
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Acute lymphocytic leukemia</u>									6 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (X) (this hospital) attended the deceased from <u>January 30, 1968</u> , to <u>February 11, 1968</u> , that (X) (we) last saw the deceased alive on <u>February 11, 1968</u> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death										
22b. SIGNATURE <u>Richard A. Creech, M.D.</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>Feb. 11, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>Richard H. Creech, M.D.</u>					22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2/13/68		Calvary Cemetery		Fairfax, Virginia				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Falls Church Funeral Home, Falls Church					FEB 16 1968		<u>Charles Judge</u>			



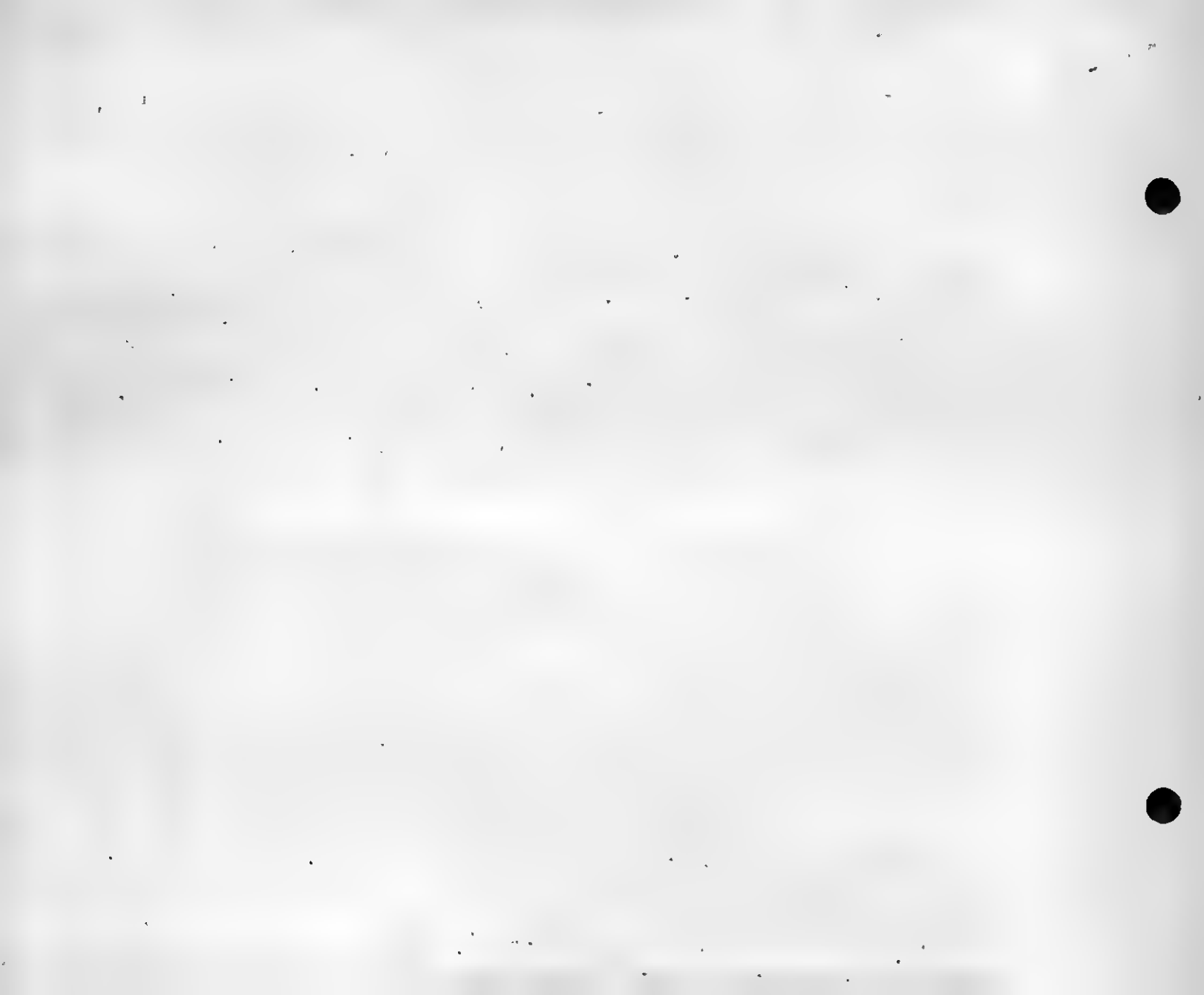


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VA AIS (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) First Middle Last Jessie Lela Virts						2a. DATE OF DEATH (68) Month 2 Day 14 Year 68		2b. HOUR M		
3. SEX Female		4. RACE W. White		5. DATE OF BIRTH 9-15-92		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Nurs. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md -			13b. COUNTY Prince George's		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10530 Edgefield Drive	
14. FATHER'S NAME First Middle Last Hector PEACOCK			15. MOTHER'S MAIDEN NAME First Middle Last JOSEPHINE MOCKS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 219-54-8069		17. INFORMANT Address LUTHER J VIRT 10530 EDGEFIELD DR ADELPHI MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4276 Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recovering CVA's DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-6 weeks										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 9-29, 1965, to 2-14, 1968, that (I) (we) last saw the deceased alive on 2-10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R.H. Sondstrom				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/14/68				
22d. PHYSICIAN'S NAME (Type) R.H. Sondstrom M.D.				22e. ADDRESS 7701 Carroll Ave Takoma Park, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/16/1968		23c. NAME OF CEMETERY OR CREMATORY HILLSBORO CFM		23d. LOCATION (City or Town) (County) (State) HILLSBORO VA.				
24. FUNERAL DIRECTOR W.W. Chambers, Inc. 1400 Chapin St. NW Washington D.C. 20005				25a. REC'D BY REGISTRAR DATE FEB 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. Quinn				

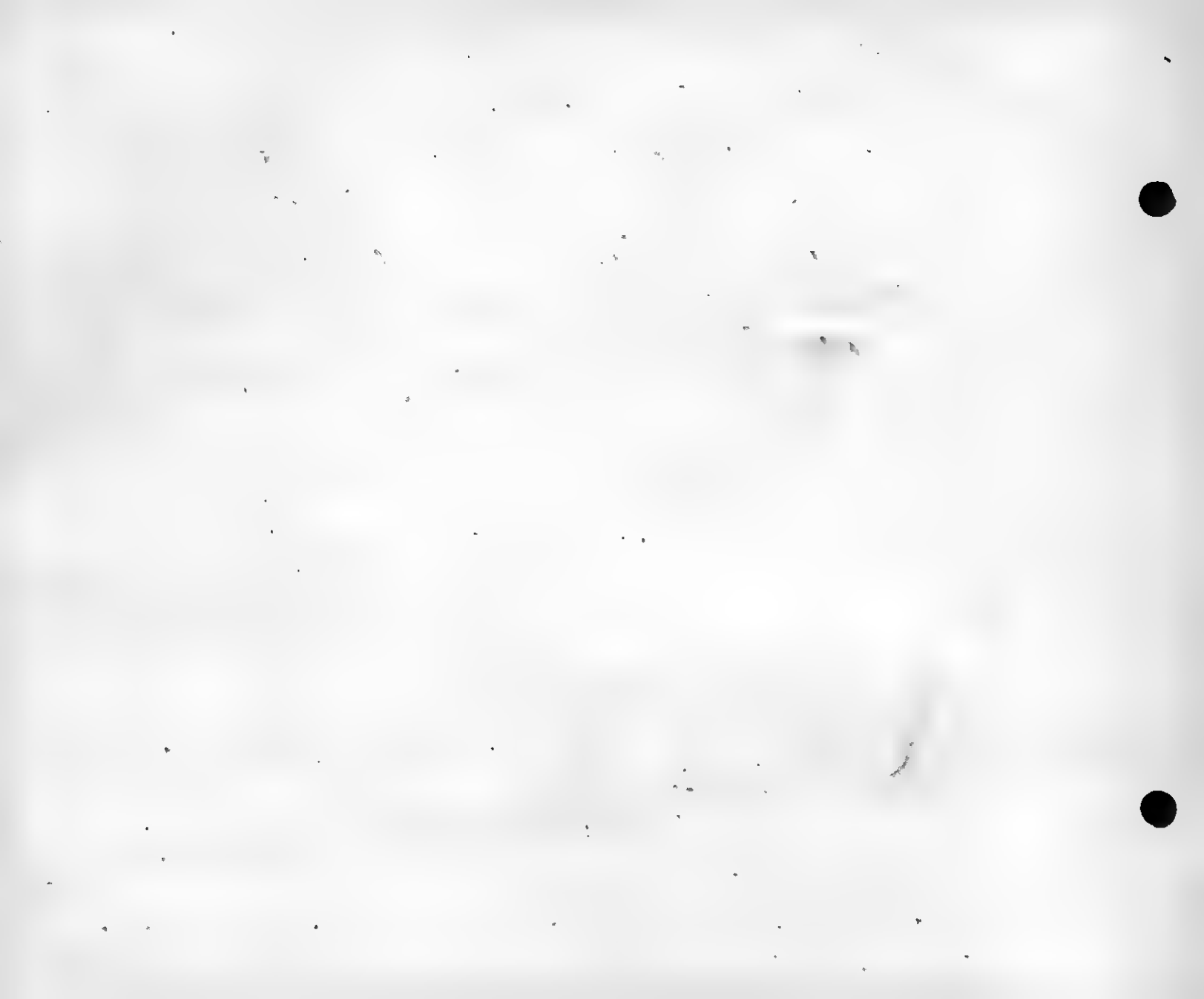


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>J GRAHAM WALKER</b>			2a. DATE OF DEATH Month Day Year <b>FEB 11 68</b>			2b. HOUR <b>1:54 M</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10-2-99</b>		6. AGE (In years last birthday) YRS <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MINS.	
7a. BIRTHPLACE (State or foreign country) <b>BROOKLINE MASS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery Md</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LAWYER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHEVYCHASE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5101 RIVER ROAD</b>	
14. FATHER'S NAME First Middle Last <b>JAMES GRIMES WALKER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>NINA CHINN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NAVY 1917</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>WIFE</b> Address <b>5101 RIVER ROAD</b> <b>MARION BOSS WALKER CH CHASE MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4104</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS, GENERAL</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>22 DAYS</b> <b>8 YEARS</b> <b>8 YRS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 1949</b> to <b>FEB 11 1968</b> , that (I) (we) last saw the deceased alive on <b>FEB 10 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert G. Angle M.D.</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>FEB 11, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>ROBERT G. ANGLE</b>				22e. ADDRESS <b>5009 Del Ray Ave. Bethesda, Maryland</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-14-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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VR A15 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: John Middle: A. Last: Walker			2a. DATE OF DEATH Month: 2 Day: 6 Year: 68			2b. HOUR M	
3 SEX M		4 RACE White		5. DATE OF BIRTH 11/8/99		6 AGE (In years last birthday) 70 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USIT		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY BUILDING	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DAMASCUS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 25011 WOODFIELD RD		13f. CITY OR TOWN DAMASCUS, MD					
14. FATHER'S NAME First: BRODIE Middle: Walker Last: Walker			15. MOTHER'S MAIDEN NAME First: ELIZABETH B. Middle: Moore Last: Moore				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) NO		16b. SOCIAL SECURITY NO 578-18-566		17. INFORMANT Address: 5128 ARMAND AV. FREDERICK T. KOCH CHAMP SPRINGS MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Poisoning DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIO-SCLEROSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 1 yr 5-6 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4+ Not Congestive Heart Failure & Hypertension							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
2 d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from MARCH, 1960, to Feb 6, 1968, that (I) (we) last saw the deceased alive on Feb 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. J. D. [Signature] DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.				22c. DATE SIGNED 2/7/68			
22d. PHYSICIAN'S NAME (Type) J. J. D. [Signature]				22e. ADDRESS 1352 University Blvd E			
23a. 8. JRIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft. LINCOLN CEMETERY		23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MD.	
24. FUNERAL DIRECTOR W. V. Chambers Co				25a. REC'D BY REGISTRAR 1400 Chapin St. NW		25b. REGISTRAR'S SIGNATURE DATE FEB 13 1968	



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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Tess</i>			First <i>P.</i> Middle <i>D.</i> Last <i>WARTH</i>			2a. DATE OF DEATH Month <i>Feb.</i> Day <i>11</i> Year <i>1968</i>			2b. HOUR <i>8:48</i> AM								
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>1/3/92</i>			6. AGE (In years last birthday) <i>76</i> YRS.			IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>			IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.								
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Randolph Hills M.H. Rd. 4011 Randolph Rd.</i>			12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired.) <i>Secretary</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>?</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE - <i>D.C.</i>			13b. COUNTY <i>D.C.</i>			13c. CITY OR TOWN <i>Washington</i>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER <i>3051 Idaho Ave. N. W.</i>					
14. FATHER'S NAME First <i>Frank</i> Middle <i>F.</i> Last <i>Warth</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>T.</i> Last <i>Weigel</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>128-07-7830</i>			17. INFORMANT Address <i>Nursing Home Records</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>337X</i> (b) <i>Cerebral Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>					
												<i>YRS.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic Renal Disease</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>8/13</i> , 19 <i>66</i> , to <i>2/11</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>2/11/68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>R.T. Benack MD</i>			DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>2/11/68</i>								
22d. PHYSICIAN'S NAME (Type) <i>R.T. Benack MD</i>			22e. ADDRESS <i>4115 Colie Dr, Wheaton, Md.</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2-17-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>WASH DC</i>								
24. FUNERAL DIRECTOR <i>Robert A. Devel</i>			ADDRESS <i>Wash DC</i>			25a. REC'D BY REGISTRAR DATE <i>FEB 19 1968</i>			25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>								





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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Sarah			Adeline Washington			February 19 1968			11:55 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		Negro		October 5, 1928		39 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.
North Carolina		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			The Clinical Center, NIH			Housewife			---
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3e. STREET AND NUMBER
Virginia			Fauquier		Warrenton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1, Box 215
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry Butler			Mary Freeman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Records Address				
No			Not available		The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute anterior myocardial infarction</u> <u>177X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widespread metastatic carcinoma of the breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours 6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Feb. 15, 1968		Pathologic Fracture Hip (L)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
					19				
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>September 4, 19 67</u> , to <u>February 19 68</u> , that <del>it</del> (we) last saw the deceased alive on <u>February 19 68</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <u>William E. Bridson, M.D.</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 20 February 1968		
22d. PHYSICIAN'S NAME (Type) William E. Bridson, M. D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Feb. 24, 1968									
24. FUNERAL DIRECTOR <u>Funeral Home Wash. D.C.</u>					ADDRESS <u>3831 Ga. Ave.</u>		25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12942

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

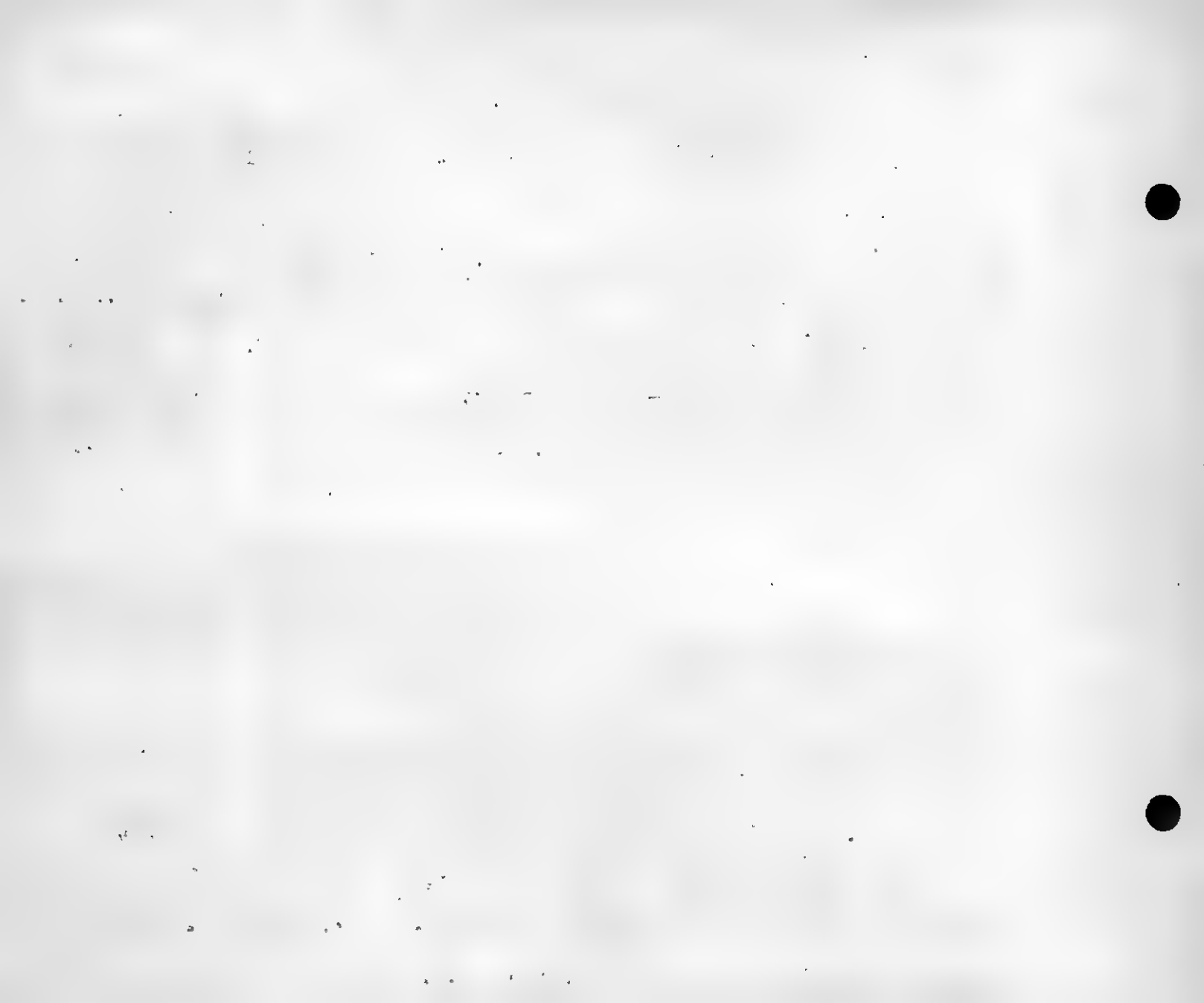
1. DECEASED-NAME (Type or print) <b>Frederick B. Watkins</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>14</b> , Year <b>1968</b>		2b. HOUR <b>1:30 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 13, 1884</b>		6. AGE (In years last birthday) <b>85</b> YRS.	IF UNDER YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN <b>00</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Etchison</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R#2, Gaithersburg</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Water Dept. Supt.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Gov't.</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>	13b. CITY OR TOWN <b>Etchison</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>R#2, Gaithersburg</b>		
14. FATHER'S NAME First <b>John</b> Middle <b>O. T.</b> Last <b>Watkins</b>		15. MOTHER'S MAIDEN NAME First <b>Evie</b> Middle <b>L.</b> Last <b>King</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>216-40-8168</b>		17. INFORMANT Address <b>Mrs Evelyn Suddath, R#2, Gaithersburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> <b>4/50</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4/50</b> (b) <b>Chronic Arteriosclerotic Heart Dis.</b> DUE TO, OR AS A CONSEQUENCE OF <b>with chronic congestive failure</b> (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Recent influenzal type viral infection</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>Feb 14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Feb 13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>G.F. Meadors</i>		MD DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/15/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>G.F. Meadors, M.D.</b>		22e. ADDRESS <b>810 Toll House Ave. Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 17, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Upper Seneca Baptist</b>		23d. LOCATION (City or Town) (County) (State) <b>Cedar Grove, Md.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		25a. REC'D BY REGISTRAR <b>Feb 19 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR				
Mary Ethel Watson						Month Day Year			3P. M.				
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
Female		Caucasian		Oct 2, 1871			91 96 YRS.						
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Virginia			U.S.						Montgomery				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Chevy Chase			Bethesda-Silver Spr. N.H.			Housewife			Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before date of admission) STATE			13b. COUNTY			13c. STREET AND NUMBER			13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Washington			D.C.			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Robert B. Patterson			Sarah T. Spencer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address				
no			-			Jean Evelyn Watson (daughter) #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Pulmonary edema										3 hours			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) Congestive heart failure										10 yrs			
DUE TO, OR AS A CONSEQUENCE OF													
(c) Arteriosclerotic heart disease										30 yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4200 Uremia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>						Street or R.F.D. No.							
22a. I certify that (I) (this hospital) attended the deceased from 1958, 19, to 2/6, 1968, that (I) (we) last saw the deceased alive on 2/3/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
John W. Latimer Jr.			2/6/68			John W. Latimer Jr.			1728 Mass Ave NW				
23a. BURIAL, CREMATON, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			2/9/68			Cedar Hill Cemetery			Suitland, Maryland				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Joseph Gawler's Sons, Inc., Washington, D.C.			FEB 13 1968										



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6901 Granby Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>Granby Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>LORA</b> Middle <b>WILSON</b> Last <b>WEBSTER</b>					4. DATE OF DEATH Month <b>FEB.</b> Day <b>24,</b> Year <b>19 68</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1868</b>		9. AGE (In years last birthday) <b>99</b> yrs. IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Archibald H. Wilson</b>					14. MOTHER'S MAIDEN NAME <b>Rosanna W Gordon</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-52-5272J1</b>		17. INFORMANT <b>Daug. Rosanna Graham</b>		Address <b>Same as Item 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> 40% DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ATHEROSCLEROSIS, CEREBRAL</b> DUE TO (c) <b>ATHEROSCLEROSIS GENERAL</b> 10% PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>33% X</b>									INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>5 YEARS</b> <b>10 YRS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 19, 1966</b> to <b>FEB. 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>JAN. 25, 1968</b> , and that death occurred at <b>7:50 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert G. Angle</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>24 FEB. 1968</b>		
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. ANGLE</b>					22d. ADDRESS <b>5009 Del Ray Ave. Bethesda, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bloomington, Indiana</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR <b>FEB 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





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Cleared with medical examiner (Dr. King) - J.H.H.

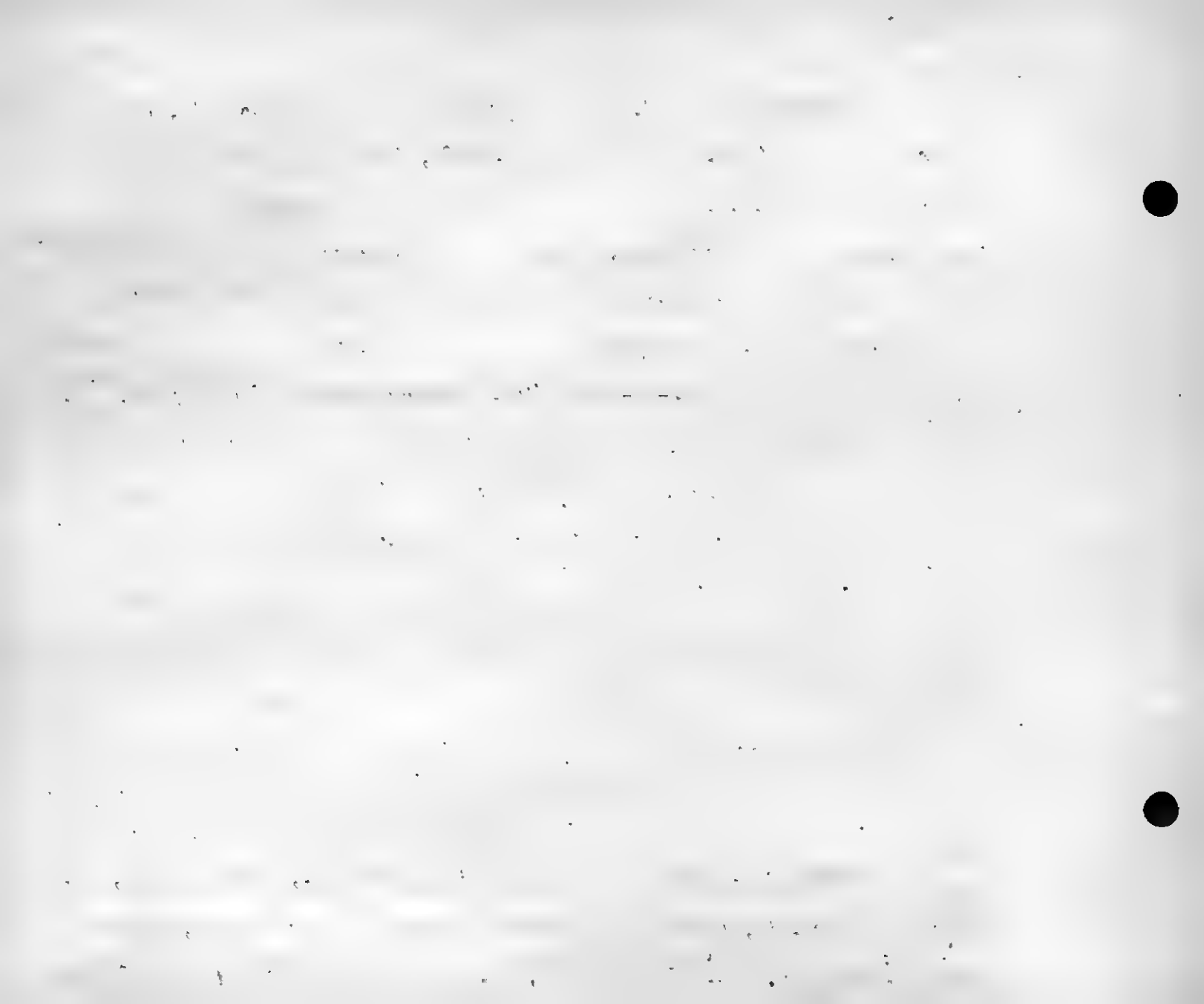
02945

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02931

1. DECEASED NAME (Type or print) First Middle Last <b>Richard A. Weppner</b>			2a. DATE OF DEATH Month Day Year <b>February 10, 1968</b>			2b. HOUR <b>11:25 PM</b>					
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5 DATE OF BIRTH <b>July 30, 1904</b>		6 AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			Md.		
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>515 Thayer Avenue</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Salesman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Imperial Plastics</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>515 Thayer Avenue</b>		
14. FATHER'S NAME First Middle Last <b>Robert A. Weppner</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Hilda Albert</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>282-05-1230</b>		17 INFORMANT <b>Mrs. Florence Weppner</b> <b>515 Thayer Avenue Silver Spring, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>CHRONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF <b>ARTERIOSCLEROTIC HEART DISEASE</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <b>RHEUMATIC MITRAL DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>ALMOST INSTANTANEOUS</b> <b>2-3 YEARS</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/12, 1967</b> , to <b>2/10, 1968</b> , that (I) (we) lost saw the deceased alive on <b>2/10, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Lawrence D. Marcus M.D.</b>				MED. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/10/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Lawrence D. Marcus</b>				22e. ADDRESS <b>1111 Spring St., Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>					
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>				ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

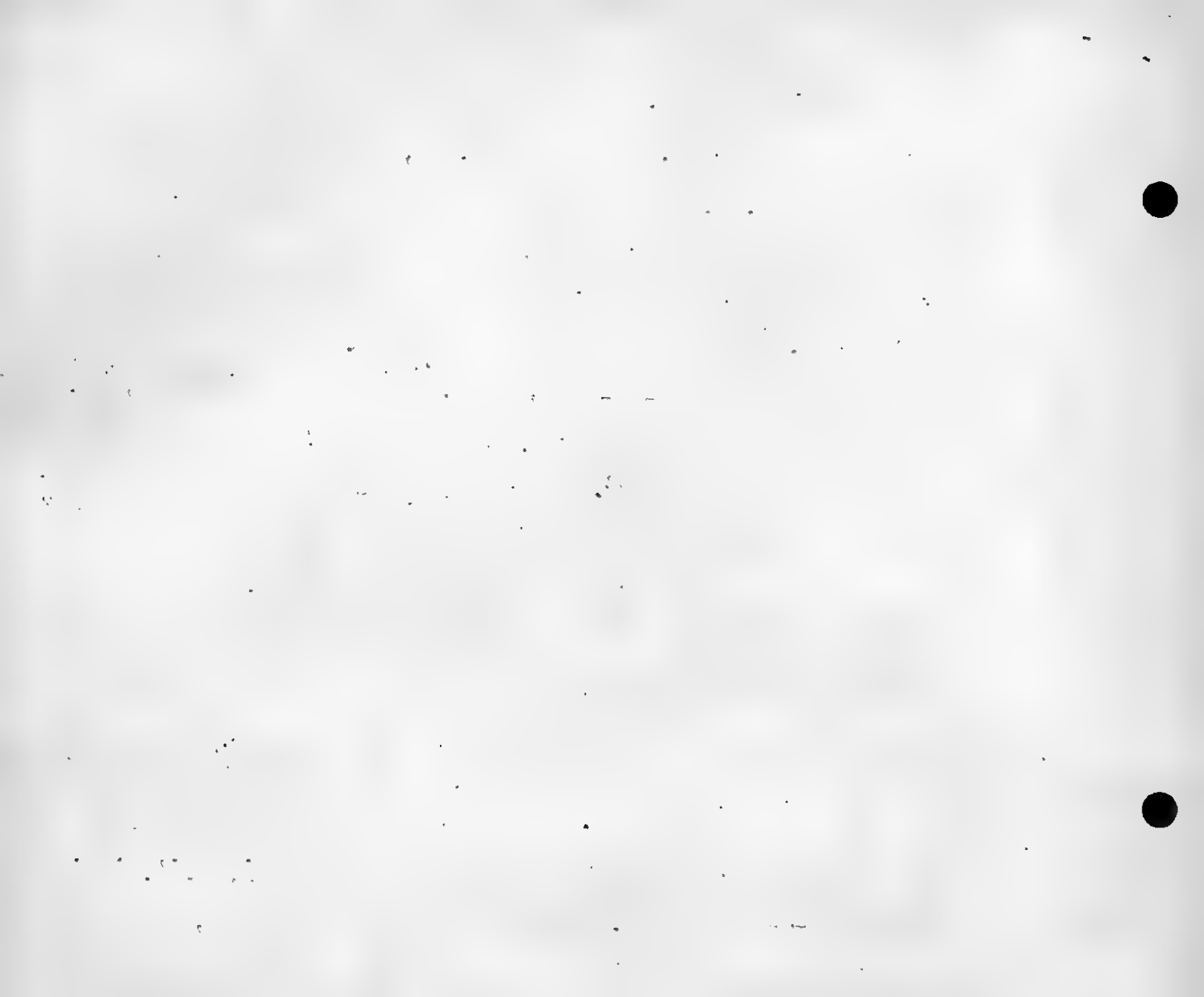
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>WILLIAM A. WEST</b>			2a. DATE OF DEATH Month <b>Feb</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>11:40 P.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>Feb. 15, 1907</b>		6 AGE (In years last birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10 CITY OR TOWN OF DEATH <b>Boyd's</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Boyd's Nursing Home</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			
13a USJA. RESIDENCE (Where deceased lived, if institution admission), STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Germantown</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route # 1</b>	
14. FATHER'S NAME First Middle Lost <b>Harry C. West</b>				15 MOTHER'S MAIDEN NAME First Middle Lost <b>Mabel L. Cross</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <b>217-36-7401</b>		17 INFORMANT <del>SEAN</del> <b>Mary V. Maughlin</b>		4000 <b>Rosedale Ave. Bethesda, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Liver Decompensation, Severe (Cholelithia)</b> <b>571.0</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Portal Cirrhosis, Severe</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6-8 Mos (Severe)</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diverticulosis - Diverticulitis, Recurrent Chronid.</b>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from <b>July 1956</b> to <b>Feb 29, 1968</b> , that (1) (we) last saw the deceased alive on <b>Feb 23 1968</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard Meyer</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3-1-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>RICHARD J. MEYER M.D.</b>				22e. ADDRESS <b>4731 Mass. Ave., N. W. Washington, D. C.</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>			
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	



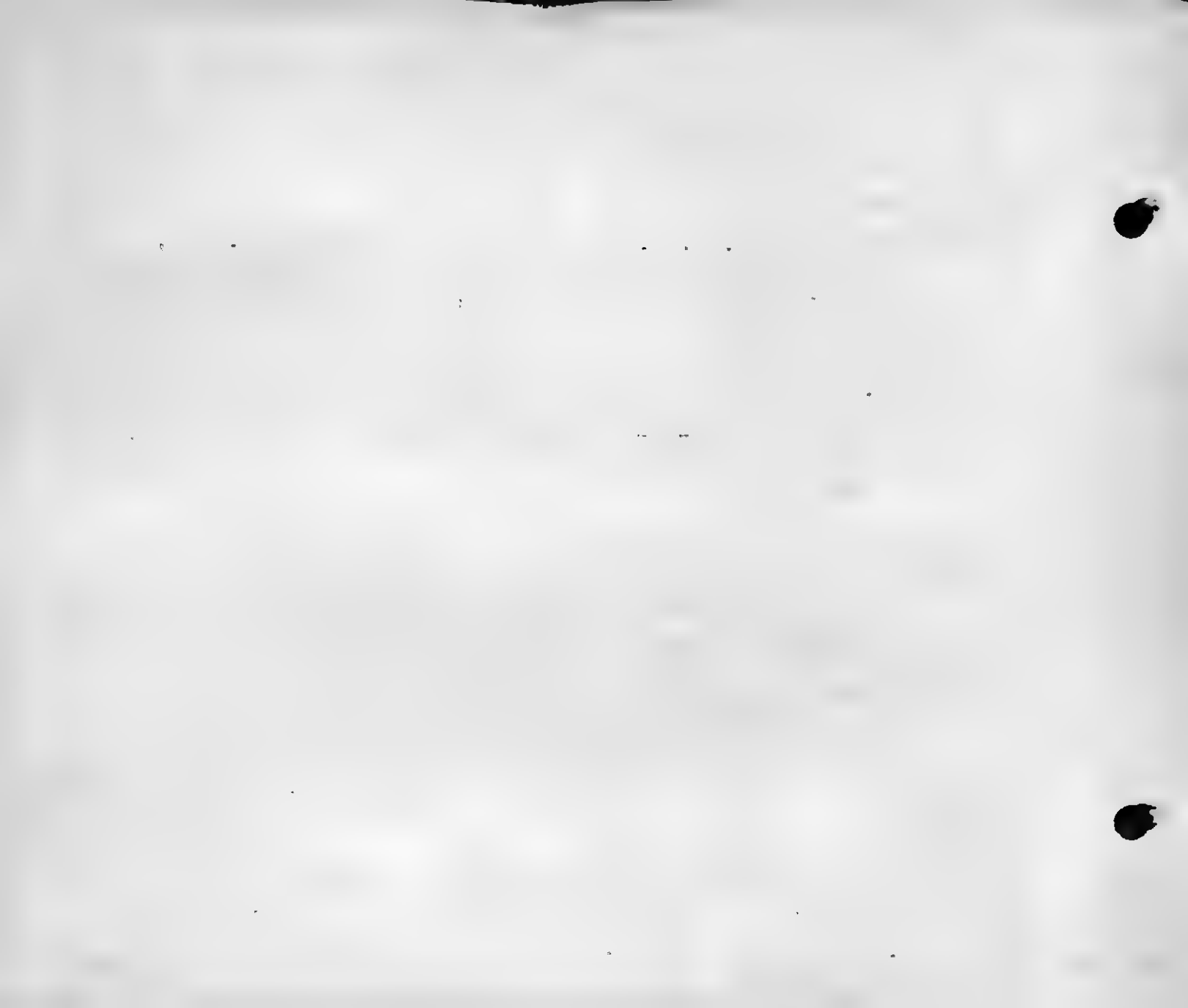
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5909 Welborn Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILIAN A. B. J. WHITMAN</b>		4. DATE OF DEATH Month Day Year <b>Feb. 18, 19 68</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1896</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>China</b>	
11. BIRTHPLACE (State or foreign country) <b>Great Britain</b>		12. CITIZEN OF WHAT COUNTRY? <b>Great Britain</b>	
13. FATHER'S NAME <b>Henry B. Joly</b>		14. MOTHER'S MAIDEN NAME <b>Li Wilkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>031-22-0472</b>	
17. INFORMANT <b>Husband</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>151</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the stomach</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>151</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 17</b> , 19 <b>68</b> , to <b>Feb 18</b> , 19 <b>68</b> , that I last saw the deceased alive on <b>Feb 17</b> , 19 <b>68</b> , and that death occurred at <b>1:30</b> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Lynch</b>		M.D. <b>1234-19 8C NW WASH DC 20036</b> DATE SIGNED <b>2/18/68</b>	
PHYSICIAN'S NAME (Type) <b>JOHN J. LYNCH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2-20-68</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 26 1968</b>	
24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

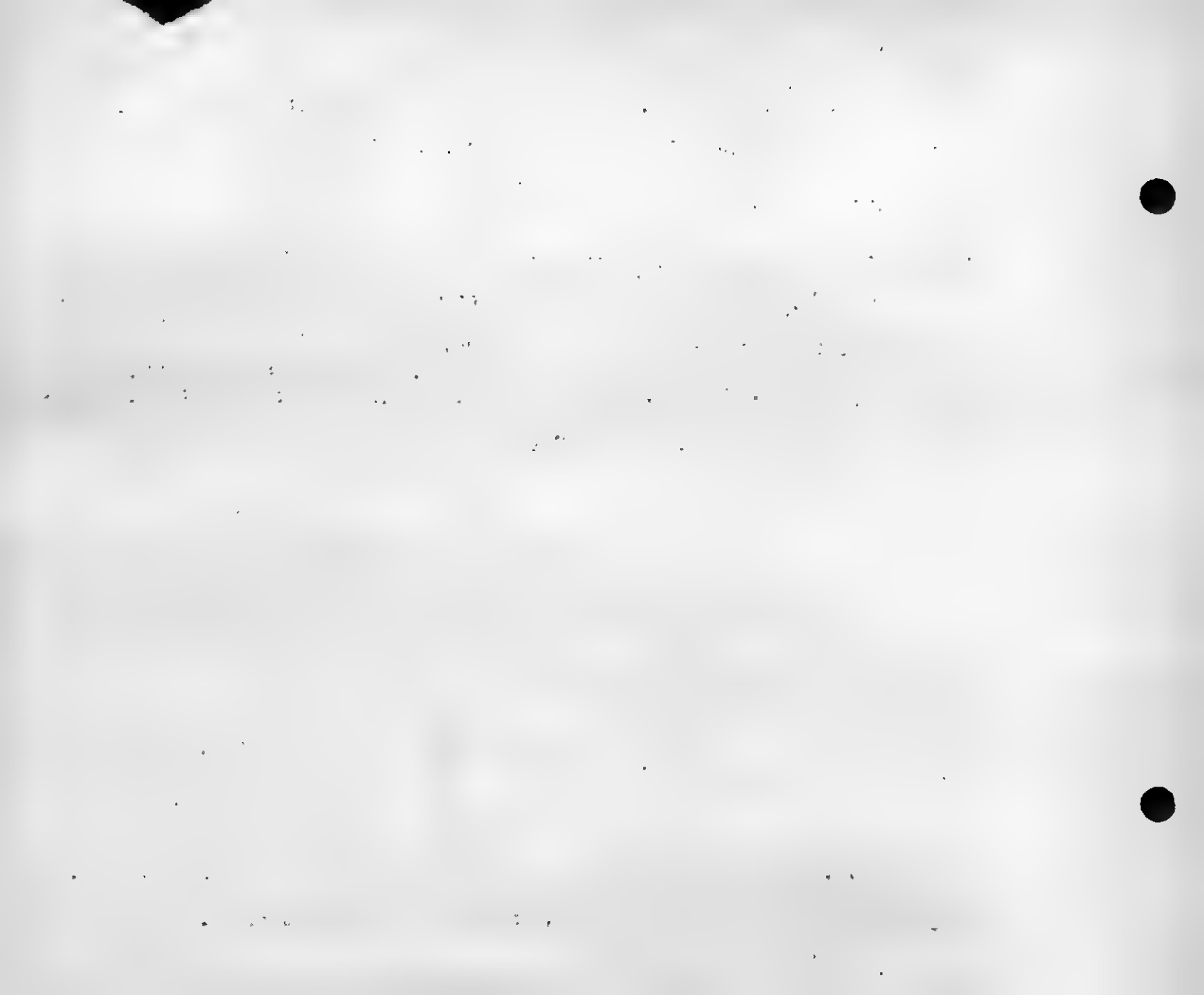


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>Frederick C. WIESNER</b>			2a DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1968</b>		2b HOUR <b>612 PM</b>
3. SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH <b>22 June 1896</b>		6 AGE (In years last birthday) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS <b>71</b> DAYS <b>71</b> HOURS <b>71</b> MIN.
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Montgomery</b> Md		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Civil Service/Consulting</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Virginia</b>		13b. COUNTY <b>Arlington</b>	13c. CITY OR TOWN <b>Arlington</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>2030 North Adams St.</b>
14 FATHER'S NAME First <b>Joseph</b> Middle <b>Wiesner</b> Last <b>Wiesner</b>		15 MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Rust</b> Last <b>Rust</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (na, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I / WW II</b>		16b. SOCIAL SECURITY NO <b>190 14 8216</b>	17 INFORMANT <b>St. Arlington</b> Address <b>Va.</b> <b>Mrs. Nadine Wiesner, 2030 N. Adams</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> <b>772 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>23 Feb. 1968</b> to <b>24 Feb. 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>24 Feb. 1968</b> and that in <input checked="" type="checkbox"/> (my/our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C.S. REEVES</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>C.S. REEVES LT MC USN</b>		22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/28/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington, National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24 FUNERAL DIRECTOR <b>Jos. Gawler &amp; Sons</b>		ADDRESS <b>5130 Wisconsin Ave., N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>MAN 1</b> 1968 REGISTRAR'S SIGNATURE <i>James J. George</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
Item 6 Film G398 3/5/68 ap													
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P 3:45 M				
Hansel			(NMN) Williams			February 21 1968							
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (in years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS. HOURS MIN.		
Male		White		September 6, 1941			26 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Kentucky			USA						Montgomery			Md.	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY U. S.				
Bethesda			The Clinical Center, NIH			Boat Operator			Coast Guard				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
Michigan			-- U			Ypsilanti			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6170 Whittaker Road	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Toy Williams			Flora Howard										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			The Medical Records Address				
Yes (no, or unknown) Yes 1959 - 1967			147-32-4938			The Clinical Center, Bethesda, Md.			20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Myocardial failure													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Calcific mitral stenosis													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Rheumatic Heart Disease													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)													
19a. DATE OF OPERATION													
21 Feb 1968													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED													
Mitral stenosis													
20a. AUTOPSY?													
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes													
21a. ACCIDENT WAS UNDERLYING													
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH													
(If either, notify medical examiner)													
21b. TIME OF INJURY													
HOUR A.M. Month Day Year													
P.M. 19													
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED													
While <input type="checkbox"/> Not while <input type="checkbox"/>													
at work <input type="checkbox"/> at work <input type="checkbox"/>													
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.													
21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (X) (this hospital) attended the deceased from February 11, 1968, to Feb 21, 1968, that (X) (we) last saw the deceased alive on February 21, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.													
22b. SIGNATURE													
MD DEGREE													
ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>													
22c. DATE SIGNED													
2-22-68													
22d. PHYSICIAN'S NAME (Type) Lynn M. Peterson, MD													
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)													
23b. DATE													
2-26-1968													
23c. NAME OF CEMETERY OR CREMATORY													
23d. LOCATION (City or Town) (County) (State)													
WOODSTOWN N.J.													
24. FUNERAL DIRECTOR													
ADDRESS													
25a. REC'D BY REGISTRAR													
25b. REGISTRAR'S SIGNATURE													
DATE FEB 26 1968													



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed with a 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

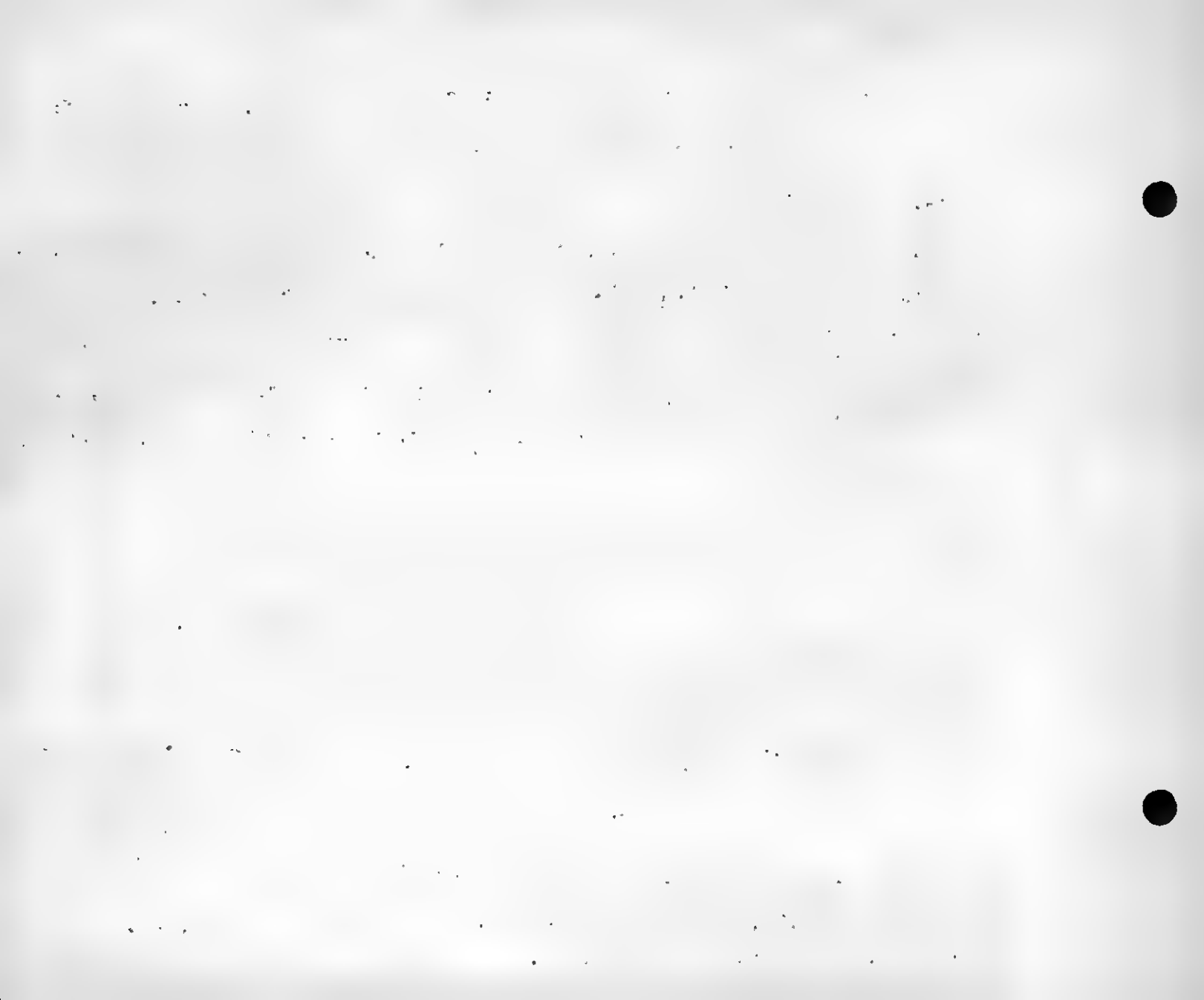


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Madalene Mary Williams</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1968</b>			2b. HOUR <b>5:05 AM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8-4-11</b>		6. AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery Md</b>					
10. CITY OR TOWN OF DEATH <b>Olney</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7315 Bowie Rd.</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>Karle</b> Last <b>Webb</b>			15. MOTHER'S MAIDEN NAME First <b>Myrtle</b> Middle <b>Webb</b> Last <b>Webb</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT <b>Montgomery General Hospital</b>			Address <b>Olney, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>2/26/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/16, 1963</b> , to <b>2/26, 1968</b> , that (I) (we) last saw the deceased alive on <b>FEB. 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles S. Whitaker, M.D.</b>						DEGREE <b>DEGREE</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/26/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Charles Whitaker</b>						22e. ADDRESS <b>CLARKSVILLE, MD. 21029</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chapel Lawn</b>				23d. LOCATION (City or Town) (County) (State) <b>Dallas, Pa.</b>			
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 28 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02831

1 DECEASED NAME (Type or print) First Middle Last MARGARET STEWART WILLSON			2a. DATE OF DEATH Month Day Year 2 11 68		2b. HOUR a 5:10 PM
3. SEX Female	4 RACE White	5. DATE OF BIRTH 5/21/86		6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery Gen'l.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 14710 Carrollton Road	
14. FATHER'S NAME First Middle Last Robert S. Stewart			15. MOTHER'S MAIDEN NAME First Middle Last Jane Moran		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) no		16b. SOCIAL SECURITY NO	17. INFORMANT Address Montgomery General Olney, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis, Rt. coronary artery DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Ulceration, urinary bladder					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 19 58, to Feb 11, 19 68, that (I) (we) last saw the deceased alive on Feb 10, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard A. Yates		DEGREE ATTENDING PHYS.		22c. DATE SIGNED 2/11/68	
22d. PHYSICIAN'S NAME (Type) Richard A. Yates		22e. ADDRESS Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-15-68	23c. NAME OF CEMETERY OR CREMATORY St. Raymond Cemetery		23d. LOCATION (City or Town) (County) (State) N.Y.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR FEB 19 1968	25b. REGISTRAR'S SIGNATURE [Signature]





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or Print)			First Ellen			Middle A.			Last Winckler			2a. DATE KNOWN OF DEATH Month 2 Day 17 Year 1968			2b. HOUR 11:35 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10/23/1875		6. AGE (in years last birthday) 92		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 2 Day 7 Year 1968			2d. HOUR 11:35 P.M.				
7a. BIRTHPLACE (State or foreign country) Sweden				7b. CITIZEN OF WHAT COUNTRY? Unknown USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md							
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Maryland				13b. COUNTY Pr. George				13c. CITY OR TOWN Seabrook				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 9787 Telegraph Road			
14. FATHER'S NAME First Middle Last Carl Anderson						15. MOTHER'S MAIDEN NAME First Middle Last Frederika Nyman													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS records: Montgomery General Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonitis, bilateral</u> 486 x DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 486																			
19a. DATE OF OPERATION Feb. 3, 1968						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture, left hip						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year 10-2-2 1968						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Patient fell in Nursing Home							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office, build ng, etc.) Simons Nursing Home						21f. LOCATION (Street or R.F.D. No. City or Town County State) Scaggsville, Howard Cty., Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED Feb. 8, 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify) removal						23b. DATE 2/8/1968		23c. NAME OF CEMETERY OR CREMATORY Old Swedish Cemetery				23d. LOCATION (City or Town) (County) (State) Worcester, Mass.							
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc 5130 Wisconsin Ave. NW, Wash. DC						25a. REC'D BY REG. STRAR DATE FEB 13 1968						25b. REGISTRAR'S SIGNATURE J. J. J.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
FANNIE					WOLF	Month	Day	Year	2:10 M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
Female		White		May 30 1896		72 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
England		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY (M.T.S?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Silver Spring			8201 16th Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Wolf					Glassman	Annie			----
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No						Son-in-law			Ch.Ch., Md.
						Stanley Hayman-3130 Brooklawn Terr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the prostate</u> 1067 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <u>lung, colon, liver</u> stating the underlying cause last. (b) <u>lung, colon, liver</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>117</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (the hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>2-21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					MD DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Bernard Ostrow</u>									<u>2-21-68</u>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Dr. Bernard Ostrow					8107 Eastern Ave., Sil. Spg., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		2-22-68		B'nai Israel Cemetery		Oxon Hill, Maryland			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Bernard Danzansky & Sons					Washington DC		FEB 23 1968		<u>Charles J. J...</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV (4)  
1968

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>Mary A. Wolfe</i>					2a. DATE OF DEATH <i>Feb 20 1968</i>			2b. HOUR <i>5P M</i>	
3. SEX <i>Female</i>		4. RACE <i>White USA</i>		5. DATE OF BIRTH <i>May 23, 1890</i>		6. AGE (In years last birthday) <i>77</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Penna</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Hanging Rock Md</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Henningston Gardens Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Tak. Park</i>		13c. CITY OR TOWN <i>Tak. Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7014 Sycamore Avenue</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>Adams</i> Last <i>Adams</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Scully</i> Last <i>Scully</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO <i>577-48-1932</i>		17. INFORMANT <i>Mrs. Daniel C. Shale</i>		Address <i>7012 Eastern Ave NW</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis (Extensive)</i> DUE TO, OR AS A CONSEQUENCE OF <i>Gen Arteriosclerosis &amp; Hypertensive</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>At 100 years of age</i> (c) <i>At 100 years of age</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1/17/68</i> <i>15 yrs</i> <i>3 yrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medico-examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/17/53</i> , 19 <i>1968</i> , to <i>2/20/68</i> , that (I) (we) lost saw the deceased alive on <i>6/20/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Howard T. Morse</i>				22c. DATE SIGNED <i>2/20/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Howard T. Morse MD</i>			
22e. ADDRESS <i>2630 Carroll Ave Takoma Park Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 23, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>		23d. LOCATION (City or Town) <i>Adelphi</i>		23e. (County) <i>Pr Geo Co</i> (State) <i>Md</i>	
24. FUNERAL DIRECTOR <i>John H. Walters</i>				25a. RECEIVED BY REGISTRAR <i>257 Carroll St NW - DC</i>		25b. REGISTRAR'S SIGNATURE <i>John H. Walters</i>		DATE <i>FEB 23 1968</i>	

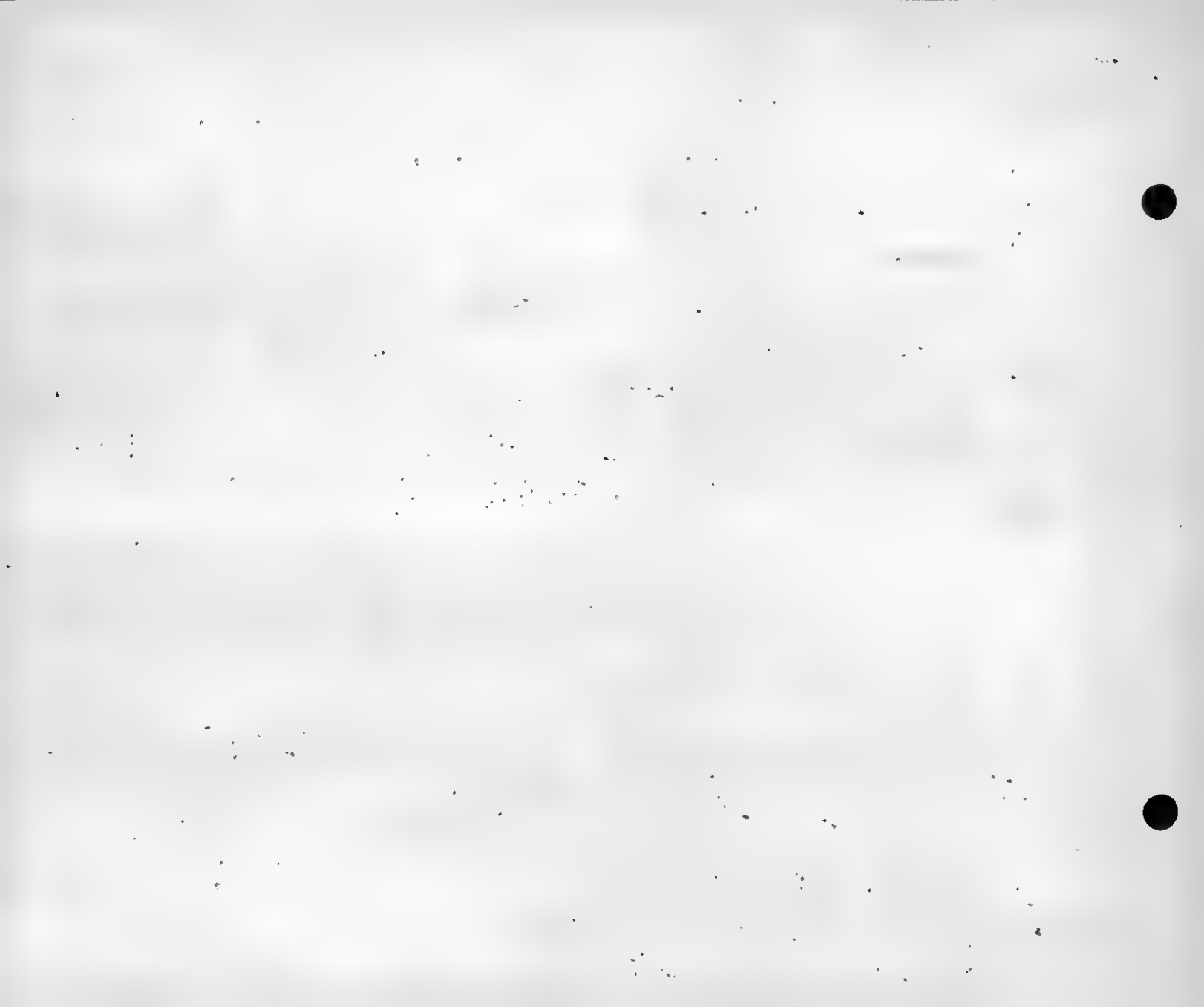


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Reported to County Coroner by Dr. John Ball & W. Schick

2956										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										2941									
1 DECEASED-NAME (Type or print) First Middle Last WILLIAM W. WOODSIDE										2a. DATE OF DEATH Month Day Year Feb. 25, 1968										2b. HOUR 1:30 PM									
3. SEX Male					4. RACE Cauc.					5. DATE OF BIRTH Apr. 9, 1875					6. AGE (In years last birthday) 92 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Penna.					7b. CITIZEN OF WHAT COUNTRY? U. S.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md.														
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9706 Parkwood Drive					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland					13b. COUNTY Montgomery					13c. CITY OR TOWN Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 9706 Parkwood Drive									
14. FATHER'S NAME First Middle Last Thomas Woodside					15. MOTHER'S MAIDEN NAME First Middle Last Alice Turner																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No					(If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 193-07-7905					17. INFORMANT Son Address Gilbert Woodside Same as Item 13.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic heart disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes ?																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 5-20-1966 to 2-25-1968, that (I) (we) last saw the deceased alive on 2-22-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																													
22b. SIGNATURE George A. Gray M.D.					22c. PHYSICIAN'S NAME (Type) GEORGE GRAY					22d. ADDRESS 4740 Chevy Chase Drive Chevy Chase, Maryland					22e. DATE SIGNED 2/26/68														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE Feb. 28, 1968					23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery					23d. LOCATION (City or Town) (County) (State) Champion Pennsylvania														
24. FUNERAL DIRECTOR Robert G. Humphrey					ADDRESS Bethesda, Maryland					25a. REC'D BY REGISTRAR MAR 4 1968					25b. REGISTRAR'S SIGNATURE Charles Judge														



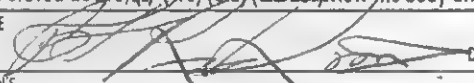
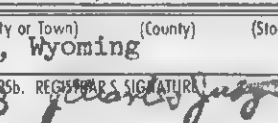


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

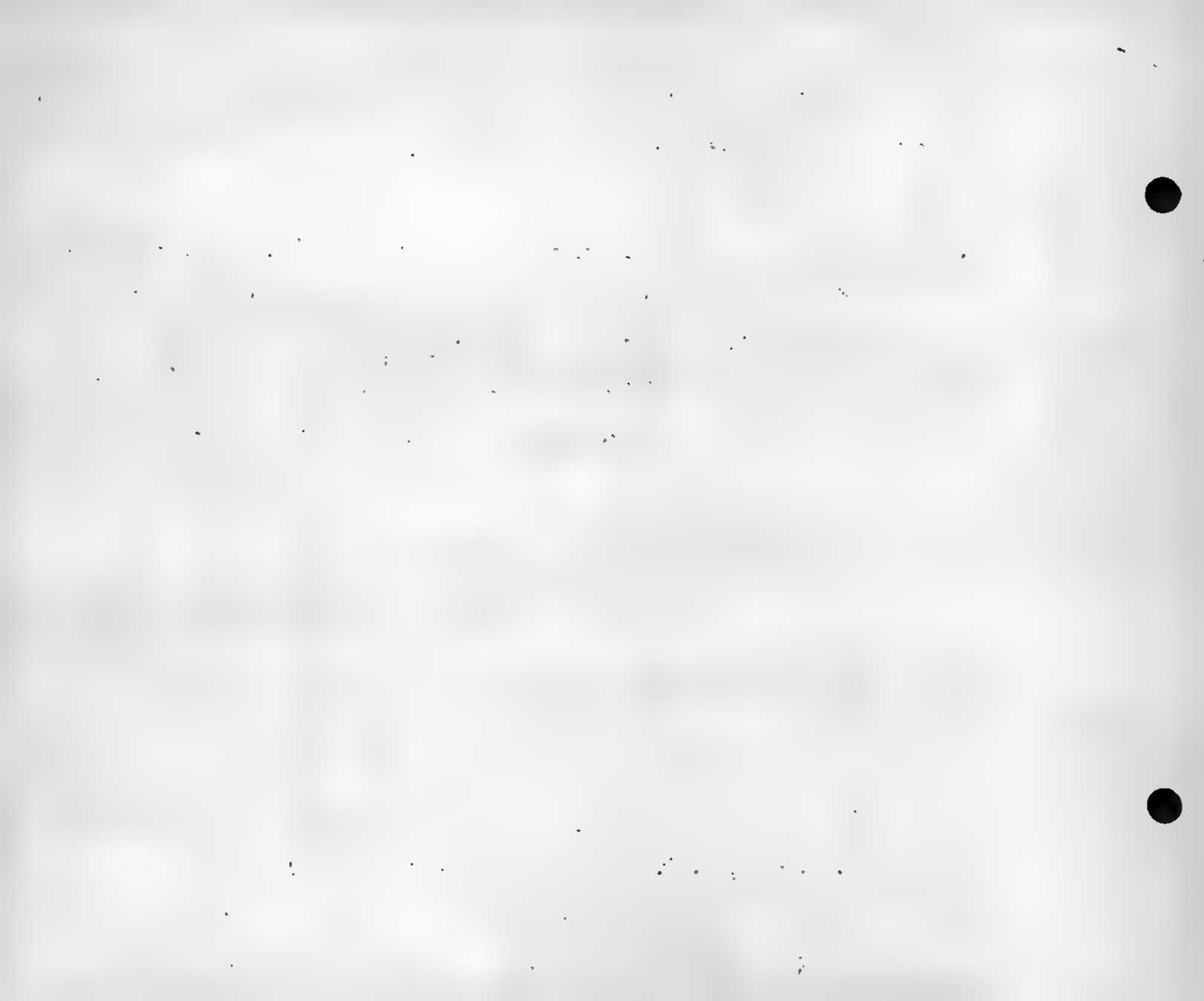
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Cynthia Jean Worf</b>		2a. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>68</b>		2b. HOUR <b>1045</b> P <b>M</b>
3 SEX <b>Female</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Jan. 16, 1928</b>		6. AGE (In years last birthday) <b>40</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Wyoming</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary/Consular Assist.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Wyoming</b>	13b. COUNTY <b>Sheridan</b>	13c. CITY OR TOWN <b>Sheridan</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>535 Airport Road</b>
14. FATHER'S NAME First <b>Russell</b> Middle <b>A.</b> Last <b>Worf</b>		15 MOTHER'S MAIDEN NAME First <b>Gladys</b> Middle <b>Olsen</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>520 26 9889</b>	17. INFORMANT <b>Sheridan</b> Address <b>Wyoming</b> <b>Mr. Russell A. Worf 535 Airport Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture aneurysm of the right middle cerebral artery</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		
21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>Feb. 9</b> , 19 <b>68</b> , to <b>Feb. 12</b> , 19 <b>68</b> , that <b>I</b> (we) last saw the deceased alive on <b>Feb. 12</b> , 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <b>I</b> (we) (did) (do not) view the body after death.				
22b. SIGNATURE 		22c. DATE SIGNED <b>13 Feb. 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>B. L. RISH, M. D.</b>		22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>		
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	23b. DATE <b>2-17-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Willow Grove,</b>	23d. LOCATION (City or Town) (County) (State) <b>Buffalo, Wyoming</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b> <b>7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 19 1968</b>		25b. REGISTRAR'S SIGNATURE 

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form WM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
Marian Elizabeth Wright						Month Day Year			1 11 PM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR			
F	Negro	1/13/32	36 YRS.	MONTHS DAYS	HOURS MIN	Month Day Year			1 11 PM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		USA				Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hsp				Teacher Aide			Book of Ed			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Md		Mont		Suburban				R.F.D. #1				
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME									
First Middle Last			First Middle Last									
Twyman			Josephine									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No						Husband William Wright			Same as above			
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>									12 hr.			
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <u>hypertensive cardiovascular disease</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
44												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. P.M.		19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
John B. Bell						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Feb. 22, 1968			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
								DATE FEB 29 1968		J. Charles Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Virginia Frances Wyatt						February Month 26 Day 1968 Year			7:15 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		11/25/89		78 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Va.		USA.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Wheaton				11611 Grandview Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Alvin Philip Lum			Laticia S. Britton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			227-05-1379D		Mr. Alvin H. Simmons 11611 Grandview Avenue Wheaton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary edema									6 hrs	
DUE TO, OR AS A CONSEQUENCE OF										
(b) coronary heart disease									3 yrs	
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201 Cholecystitis, generalized atherosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/2/68, 19, to 2/26/68, 19, that (I) (we) lost the deceased on 2/25/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
Patrick Jameson								22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Patrick Jameson				11718 Georgia Ave Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2/29/68		Oakwood Cemetery		Richmond, Virginia				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTAR		25b. REC'D BY SIGNATURE			
Warner E. Pumphrey, Inc. Silver Spring, Md.					FEB 29 1968					



MEDICAL EXAMINER - (Dr John Ball) Notified - Will Approve

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL EXAMINER - DR JOHN BALL NOTIFIED - WILL APPROVE

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>MORRIS KENNETH YOCHELSON</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>7</b> Year <b>68</b>			2b. HOUR <b>8:55 PM</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12-27-84</b>		6. AGE (In years last birthday) <b>80</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>AMER</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH SAN + HOSP</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED - FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>M.C. SILVER SP.</b>			13c. CITY OR TOWN <b>SILVER SP.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1401 BLAIR MILL RD</b>	
14. FATHER'S NAME First Middle Last <b>Yehiel</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Leah LEVINSKY</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>			16b. SOCIAL SECURITY NO. <b>578-46-6009</b>			17. INFORMANT <b>Baron Yochelson (son)</b> Address <b>2306 East West Hwy. S.E. Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>MYOCARDEAL INFARCTION, ACUTE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>DUE TO EMPHYSEMA</b>											
PNEUMOTHORAX-PARTIAL LEFT S											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DIABETES MELLITUS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>2-5-</b> , 19 <b>68</b> , to <b>2-7-</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-7-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Samuel A. Hillman MD</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-8-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>SAMUEL A. HILLMAN, MD.</b>					22e. ADDRESS <b>8829 FLOWER AVENUE SILVER SPRING, MD. 20901</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-9-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>HYATTSVILLE MD</b>					
24. FUNERAL DIRECTOR <b>BERNARD DANZANSKY</b>					25a. REC'D BY REGISTRAR DATE <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

